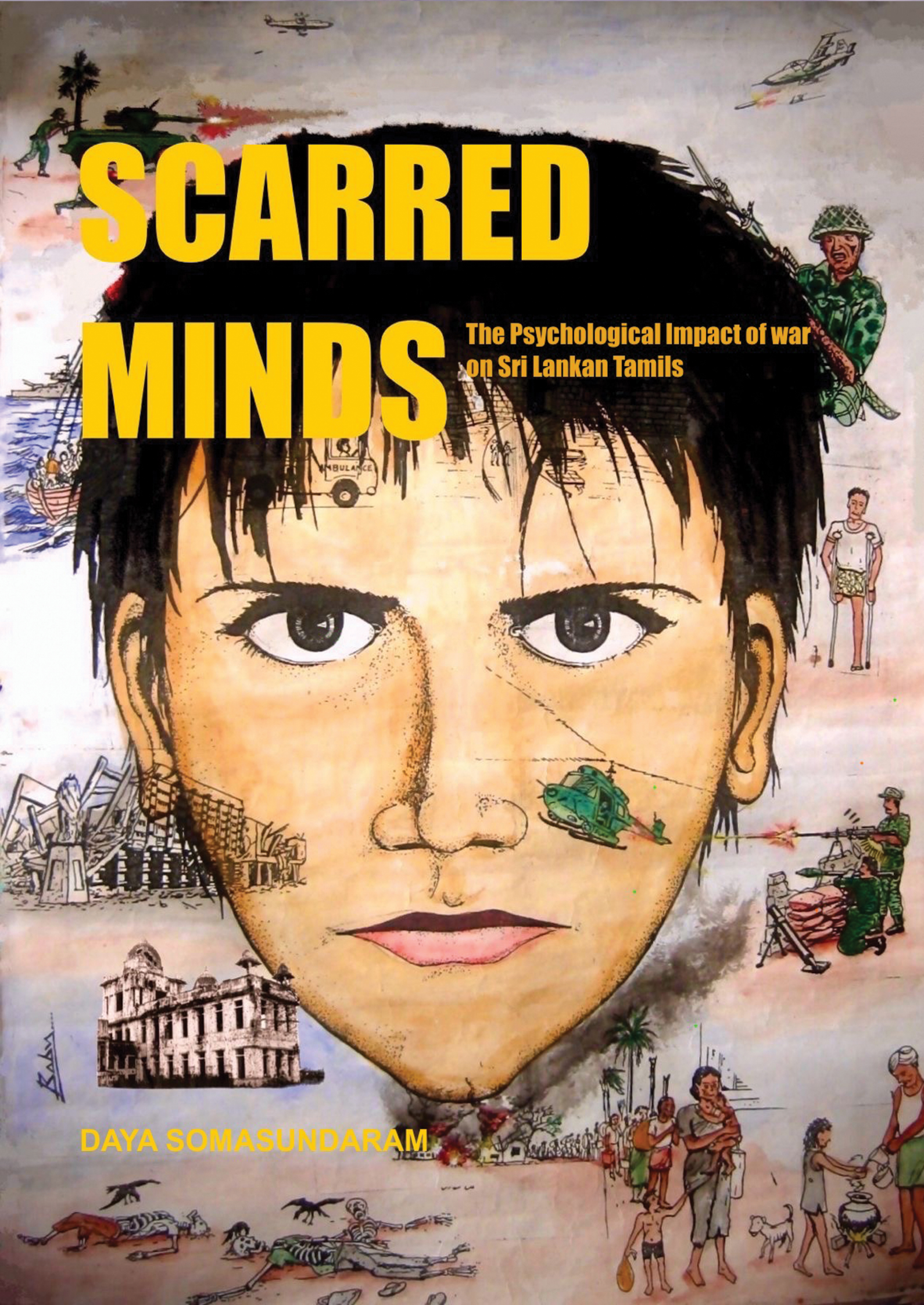

SCARRED
MINDS
The Psychological Impact of war
on Sri Lankan Tamils
DAYA SOMASUNDARAM

SCARRED MINDS

The Psychological Impact of war on Sri Lankan Tamils

DAYA SOMASUNDARAM

MBBS (India), MD (Sri Lanka), FRCPsych (UK), FRANZCP (Australia), FSLCP (Sri Lanka)

Professor Emeritus, University of Jaffna & Consultant Psychiatrist, Sri Lanka
Clinical Associate Professor, University of Adelaide, Australia

தபோவனம்
ECO WELL-BEING VENTURE

Copyright : ***Daya Somasundaram*** **©**
All rights reserved.

மனவடு (Manavadu), Tamil abbreviation of core chapters from Scarred Minds published by **University of Jaffna in 1993**

First English Version published in 1998 by:

Sage Publications India Pvt Ltd
M-32, Greater Kailash Part-I,
New Delhi 110 048.

ISBN: 81-7036-725-5 (India-Hb)
0-7619-9267-7 (US-Hb)

Library of Congress Cataloging-in-Publication Data

Somasundaram, Daya, 1951

Scarred Minds: The psychological impact of war on Sri Lankan Tamils/Daya Somasundaram.

Includes bibliographical references (p.) and index. 1. Tamil (Indic people) - Sri Lanka Psychology. 2. Sri Lanka - Politics and government. 3. Sri Lanka - Ethnic relations. 4. Violence - Sri Lanka - Psychological aspects. 5. War - Psychological aspects. I. Title. DS489.25.T3S66 616.85' 21' 008994811-dc21 1998 98-7050

Free e-Book - 2025

Free e-Book Published by: **Thapovanam**

Design by: **Wanasinghe Printers**
496A, Trinco Road, Batticaloa, Sri Lanka.
Tel. No.: 065 222 7170 | e-mail: wanasingheprinters@gmail.com.

Design Help by: **Dr. P. Judy Ramesh Jeyakumar**

Cover drawing & Image creator: **Dr. S. Naguleswaran (Babu)**
Consultant Psychiatrist, UK
(Drawn initially by Naguleswaran (Babu) as a high school student (18 years) and appeared in Manavadu)

Printing Cost Help by: **Dr. S. Agilan, Dr. P. Brighton, Dr. T. Ketharanathan, Dr. N. Rajeshkannan, Dr. T. Sivaruban, Dr. S. Nalayini, Dr. S. Naguleswaran (Babu)**

ISBN No.: 978-624-98963-6-9

Free e-book for sharing but donations are welcome to *Thapovanam Yoga and Meditation Centre,* a non-profit organization at Allaipiddy, Sri Lanka. Please see page 321 for details.

Dedicated to
The Mother

She unleashed her asuric forces, a raging tempest across the island, her furious force, a destructive fury, waves of anger, hatred, paranoia, violent aggression, and brutality, the madness called war that swept across the land; leaving a trail of fear, terror, massive deaths, injuries, trauma, loss, bitterness, sorrow, sadness, despair and hopelessness. We now badly need to invoke her benevolent face of love, compassion, nurturing, healing, reconciliation and peace.

"What has been described as existential anxiety was also observable in some cases. Death became a pressing reality and people had to deal with that fear daily. What had been quietly forgotten or submerged in the pressures and care of daily life, broke into one's awareness. Man was made aware of his existential state, the transience of life-that everything born must die one day. As death stalked the land, the veil that separated life and death was rent asunder and one stood face to face with stark reality. An existential fear gripped everyone. An old mystic compared the present war to the great forces of nature that destroyed-famine, epidemics, cyclones. Grasping for mythical symbols to express his deep feeling, he said *"Mother Kali with her Asura forces from India have descended on Jaffna. I could see her dancing (*கோரதாண்டவம்-*Korathandavam) on the streets of Jaffna in those October days."* In this book (chap. 6, Anxiety) When the old man said this, I had a vision, more a mental vision, which helped me understand what was happening…

War

Imagining they were heroic
some grabbed weapons with wrath
Horrific battles ensued
Called forth war
Body heaps filled the land
catastrophic consequences; Agh!
carnage continued; earth trembled.
Demoness was overjoyed

Survivors amidst dripping blood
triumphantly beat war drums
With egoic arrogance
killed kith and kin
Euphoric in victory
Walked high in pride,
Puffing up their breast

Earth broke, sky rumbled
Blazing fires arose
Oceans receded; waters boiled
Justice took flight; babies died
suckling their mother
Demoness laughed at the carnage
Blood flowed everywhere

People gave up their ghost
Oh! Death roared
With infuriated mouth wide open
Enclosed afflicted multitudes
Suffering masses succumbed to death
The land left desolate

Fortresses fell destroyed,
deadly shells did their dirty work
war raged on
soil mounds, homes, forests
Many lay dead everywhere
Conflagration spread
Brothers hunted each other
Lost was humanity

Machines took over the sky
enflamed, planet withered, torn apart
life burnt, whimpered, wept,
bodies fragmented, rotted
crows, vultures, dog packs, jackals
feasted on ubiquitous corpses

Like this, sorrows always ensues
Everyone, normal senses lost
Graceful minds crumble
Stop war, cause of untold miseries
Let love ripen, happiness to flower
come hurry, make a path to peace

-Murugayan, 1995 [1]

[1] Murugayan presented this Tamil poem to the author when he was Senior Assistant Registrar (SAR) at the University of Jaffna to be put in மனவடு (Manavadu) where it appeared as the epigraph. Translated to English by this book's author.

APOCALYPSE

In our own time we have seen
the Apocalypse. The earth
trembled to the dance of the dead;
bodies burst apart in the wild storm;
darkness screamed as everything caught fire
inside and out.
The last flood dragged out children and men
and threw them on the flames.

-Cheran, 1999
(Translated by Lakshmi Holmström)

From 'In a Time of Burning'

Beneath the mango tree, where three streets meet,
the bodies lie burning;
the flames rising
blacken the unfurled palm leaves above.
Smoke, fear, cruelty,
sorrow, terror.
Everything is black;
the colour of demons
when dark shadows
and hostile omens
envelop

The bodies and the hearts
which lie there, burning
at this time.
Even the birds have lost their song,
their voices suppressed.
Children forget to scream,
their shocked eyelids frozen.

The wind carries away
the ashes,
the dogs carry away
the bones.

They frog-march humanity
at gun point,
shoot it dead at the grave's edge
and shovel the earth over it
with their feet.
The walls along the streets
drip with blood
as they justify themselves.

-Cheran, 1986
(Translated by Lakshmi Holmström)

From the Introductory remarks to the மனவது (Manavadu) (Translations by author);

In our environment today, people are being affected by many traumas. Due to the continuation of the war situation, many are dying, many are being injured, many more are losing their belongings and homes: families are disturbed, the life of society is completely disorganized and disrupted. Normal peaceful life is no more. As a result, poverty and diseases are increasing. Environmental deterioration is leading to epidemics. Not only that, many are suffering from anxiety, fear and panic.

Prof. A. Thurairajah
Vice Chancellor,
University of Jaffna. 1993

Readers from Eelam would have experienced many of the events described here, as they read, they will remember-fearful noise of helicopters, bombings, destruction from shelling, refugee life amidst life's sorrows, torture, sexual violence, curfews, lack of food, economic hardships, deaths amidst destruction, loss of homes, occupation and property-their impact and mental reactions.

Prof. C. Sivagnansundaram
Dept. of Community Medicine Faculty of Medicine,
University of Jaffna.

From Reviews of Scarred Minds

It gives a comprehensive account of the civil war, describing the historical background from which it emerged, its social and psychological causes, and its effects on the psyche of the Sri Lankan population. Somasundaram writes from the position of a witness, a healer located within the situation he describes. This enables him to voice ethical and political concerns in a way that is non-judgemental yet not detached. Army personnel, militants and torture victims all appear in his book as human beings, voicing mundane concerns. This makes the violence intelligible at one level but at another level it appears as an anonymous force that is beyond their grasp.

Roma Chatterji
Delhi School of Economics, University of Delhi.

Somasundaram's comprehensive theoretical and clinical discussion of the psychological causes and effects of continuous violence is thus framed by a powerful critique of violence and an impassioned advocacy of nonviolence as the most effective way of securing political justice Somasundaram's deep and politically located commitment to his community extends beyond merely documenting suffering to trying to explain how a community's very scarring by violence perpetuates this vicious cycle. Peace can be brought about only through developing an awareness of the "unconscious psychic forces within us" and changing their direction by "an act of will."

Malathi de Alwis
Senior Research Fellow
International Centre for Ethnic Studies, Colombo.

The report is written from the viewpoint of a physician and a psychiatrist who remained in Jaffna and tried to deal with the pain and wounds sustained. The eye witness accounts of Sinhala atrocities and

massacres in northern villages indeed make depressing reading . While the author does not spare the militant groups, he emphasises that their deeds pale in significance against the massive human rights violations by the Sri Lankan Army…

Given that everybody accepts that war is an unmitigated disaster for the majority of the people affected, the author asks why certain conflicts are still considered insoluble except by violence? He traces intra-species aggression, which is unique to man, to three factors: first, identity, which can be manipulated by leaders and lead to 'militant enthusiasm' when threatened and to a search for total and extreme solutions. The second factor is perception, which creates stereotypes and labels that can become rigid and lead to self-fulfilling and paranoid attitudes. The third factor is aggression, which ties in with the perceived threats to identity and territoriality. Aggression can be transferred to the other group and prevent empathy. It can be seen as a reaction to physical and psychological pain. Such violence indicates the degree of frustration and suffering and frequently becomes a cult. The psychological effects of war can endure for several generations. This applies especially to long-lasting low-intensity conflicts. The reactions vary across time and space and can become chronic.

Dagmar Hellmann-Rajanayagam
Institute of Indology and Tibetology, Germany
University of Jaffna.

From back cover of SAGE edition

The twentieth century has been marked by a series of devastating wars. In the decades after the two global conflagrations, the world has witnessed a phenomenal increase in so-called 'low-intensity' civil wars which have engulfed entire populations.

The on-going ethnic conflict in Sri Lanka is one such war which epitomises the trauma, horror and devastation which has characterised warfare throughout human history. Using Sri Lanka as a case study, this remarkable book focuses on the little discussed aspect of the psychological trauma inflicted upon civilians caught in the midst of such conflicts.

After providing a brief account of the background to the civil strife in Sri Lanka, Professor Somasundaram presents a theoretical and clinical study of the psychological causes and effects of continuous violence and the widespread use of terror. At the heart of the book are vivid case histories of psychiatric and mental disorders treated at Jaffna University's Psychiatric Unit. An important chapter, contributed by Dr. Anna Doney, studies the sociological and psychological after-effects of torture. The book concludes with treatment and management methods which go beyond the mere medical model of disease and are based on a holistic and humanitarian approach.

The narrative shows how normality and sanity take on new meanings as entire communities adjust to the reality of their violent surroundings. Dr. Somasundaram argues that recurrent violence begets nothing but widespread destruction, mental trauma, and a breakdown in social order and individual relationships. He delves into history to show how non-violence, properly understood and practised, is a far more effective way of securing political justice.

A powerful critique of violence and a moving testimony to the sufferings of ordinary people, this first-hand account by a participant will be essential reading for psychiatrists, psycho-therapists, psychologists and sociologists. It will also be of considerable interest to those involved in peace and ethnic studies, politics and history.

Contents

Tables and Figures x

Foreword by Veena Das xi

Preface xvii

Free e-Book - 2025 xxi

CHAPTERS

ONE: Background 1

i. Geography 3

ii. Demography 7

iii. History 10

iv. Economy 16

v. Religion 21

TWO: The War Years, 1983-1997 25

i. Post-1983 27

ii. The PLOT Thickens 45

iii. An Exercise in Indian Power Projection 53

iv. The Civil War Continues 57

THREE: Psychological Causes of War 65

i. Identity 66

ii. Perception 75

iii. Aggression 82

FOUR: The Psychological Effects of War 96

i. Environmental Variables 101

ii. Personal Variables 115

iii. Response to Trauma 126

iv. Post-Stress Response 133

v. Mental Disorders 137

FIVE: Psychiatric Sequelae to a Chronic Civil War 147

i. Method 151

ii. Results: Case-Histories 151

iii. Surveys of Specific Populations 187

iv. Conclusion 189

SIX:	**Psychological Impact of an Acute War**	194
i.	Reports	196
ii.	Conclusion	226
SEVEN:	**The Psychological After-Effects of Torture**	229
	A Survey of Sri Lankan Ex-Detainees	
i.	Survey Method	237
ii.	Results	241
iii.	Discussion	253
iv.	Conclusion	256
EIGHT:	**Management**	259
i.	Treatment	259
ii.	Peace	278
iii.	Conclusion	303
Appendix I : Relaxation Techniques		306
Appendix II : Stress Impact Questionnaire (SIQ)		310
About the Authors		319
Thapovanam		321
'Alaparung Karunai' Poem		324

Tables and Figures

TABLES

1.1	Employment of Tamil Minorities	19
1.2	Changes in the Ethnic Composition of Candidates Admitted to Different Faculties in Sri Lankan Universities, (1970-1983)	20
3.1	Decline in the Privileged Position of Tamils	81
4.1	Psychological Responses to Trauma	100
4.2	Temporal Dimensions of War Trauma	102
5.1	Stress Factors in North and East Sri Lanka (1981-1987)	152
5.2	Operation Liberation, Vadamarachi Area (May-June 1987)	153
5.3	Common Symptoms in Pre-school Children (Kokuvil-Kondavil, Vaddukoddai)	182
5.4	Common Symptoms in School Children (Vaddukoddai)	183
5.5	War Stress in Adolescents (Percentages)	184
5.6	Psychosocial Problems in Adolescents (Percentages)	184
5.7	Males and Females Admitted to the Psychiatric Ward (Tellipallai)	187
6.1	Stress Factors-Operation of the Indian Peace Keeping Force in Jaffna and Other Areas (October, 1987-1988)	201
7.1	Physical Problems of Ex-detainees at the Time of Interview	246
7.2	Psychological Problems of Ex-detainees Reported Over the Two-Week Period Prior to Interview	248
8.1	Phase-oriented Treatment for Stress Response Syndromes	267
8.2	Methods of Non-violent Action	293

FIGURES

3.a	Increasing Group Identification	66
4.a	Spatial Dimension of War Trauma	106
4.b	Function of Autonomic Nervous System in Stress	127
8.a	Psychological First Aid and Triage	262

Foreword

Veena Das

In his reflections on war and on peace in *The Natural Contract*, Michel Serres draws our attention to the fact that wars have a legal status but also that this legal contract between two parties is premised on the non-recognition of what he calls the third, the world of objects.[1] He writes, 'Since the archaic times of the first Roman laws, and doubtless even earlier, war has lasted only from the very precise procedures of the declaration until those of the armistice, duly signed by those in charge, one of whose principal prerogative is precisely the power to decide on the opening and the cessation of hostilities. War is characterized not by the brute explosion of violence but by its organization and its legal status' (p. 13). Serres goes on to distinguish 'subjective wars' which are defined by law, and 'objective violence' as violence done to the earth-the third party, excluded in the contract between men that constitutes the 'theatre' of hostilities. 'So now we have fleets of sunken oil tankers, several gutted atomic submarines, a few exploded thermonuclear bombs, the subjective war of so-and-so against so-and-so suddenly counts very little in the face of the objective results of the objective violence unleashed against the world by the means at the belligerent's disposal' (p. 10). Daya Somasundaram's book is one of the finest contributions that I know of, which looks closely at this excluded third party by expanding the meaning of this 'thirdness' to privilege those whose lives are severely damaged by the ravages of declared and undeclared wars but who are not themselves parties to these contracts in the exchange of violence.[2]

Many of the recent works on collective violence in Sri Lanka (and generally in South Asia) seem to work with an implicit distinction between civil violence as epitomised in the phenomenon of the riot, and war as violence undertaken under the sign of the State. Somasundaram's careful analysis of the situation in Sri Lanka in what he names as 'the war years' of 1983 to 1997 shows that the boundaries between state violence and civil violence, or between violence unleashed in private and that used in public are very difficult to maintain. Even the naming of the violence alternatively as guerrilla war, ethnic strife, war for Eelam, or civil war, points to the distance between the conceptualisation of war as legal contract and as social experience. The violence in these years in Sri Lanka did not always reach the degree or intensity of a conventional battle. Rather, it was in the character of a chronic, periodic, low-intensity conflict, punctuated with guerrilla type attacks, followed by reprisals against civilians. There were occasional acute phases of total war situations when the army (Sri Lankan and in one phase Indian) went all out to capture an area, but these phases were short. Instead, what marked the period was the merging of different kinds of violence that resulted in experience of massive trauma for the Tamil population, especially in the northern and eastern parts of Sri Lanka.

In retrospect the event that marked a shift in the level of conflict between the Tamil minority asking for their rights and the State in Sri Lanka were the events of 23 July 1983. Following the ambush of an army convoy on this date by Tamil militants, 13 soldiers were killed. The army in reprisal went on a shooting spree; this was followed by massive violence against the Tamils in Colombo. It was this violence and the complicity of the forces of the State with the crowds made up of Sinhalese thugs (often described as the lumpen elements) that convinced many Tamils of the legitimacy of militant action:

recruits poured into various Tamil organisations. As the violence intensified, it led to the raising of the stakes at all levels. By the mid-1980s roughly 25 percent of the Tamil population of the North and East became refugees. The estimates suggest that 225,000 Tamils left Sri Lanka seeking asylum in several countries in Europe, North America, Canada, Australia, New Zealand and India. The largest refugee influx was in India-about 150,000 refugees were recorded as having fled to India. Therein begins a new stage of the story leading to both, intensification of the conflict within Sri Lanka by militant groups, many of which were organised and received training in India; and the globalisation of the conflict in which expatriate Tamils could both speak for the suffering of the Tamils of Sri Lanka in international forums but also stake their own claims from a distance in the struggle for Eelam. The events are told with a rare clarity by Somasundaram. The tragic dimension of the events is that even when Jaffna continued to function as a 'semi-liberated territory' under the control of the LTTE, there was a silencing of any dissent. There has been brutal elimination of those who spoke for human rights but were seen as enemies by the LTTE (such as Dr. Rajani Thirangama, a lecturer in anatomy at the Jaffna Medical College); and the factional fights among the militants have made ordinary life fraught with danger and despair. This, despite the fact that in some phases, the LTTE cadre was able to deliver public services efficiently and equitably. As Somasundaram puts it, 'To many it was a time of hope and exhilaration ending in disillusionment and despair.'

Throughout the period described in this book the Tamil population of the North and East in Sri Lanka had to suffer violence which was sometimes spectacular, sometimes hidden, sometimes organised, sometimes random, in a way that their ordinary, everyday world became irretrievably lost to them. The sources of this violence were as varied as its character. Violence came from one or the other militant groups active in the region[3] and often in competition with each other-it came from the Sri Lankan security forces; and it came from the Indian Peace Keeping Force (IPKF) which was initially welcomed in the island as a friend by the Tamil population and then within a brief period became transformed into a source of terror. It is clear from Somasundaram's account that the boundaries between the different kinds of violence have become very fuzzy in the modern world-ethnic violence gets mutated into violence by the state; peace keeping becomes a way of unleashing random terror on civilian populations, not to speak of the violence on the earth and thus on future generations with which Serres is so rightly concerned.

In the classical mode of understanding collective violence (a category in which war is not normally included), scholars have tried to theorise on the character of crowds-how crowds are formed; what are the networks that are articulated in the actualisation of crowd violence; how are we to understand the social psychology of crowds? The assumption is that while we witness disciplined violence in the case of war, we are confronted with unregulated violence in the case of crowds which act out their fantasies in appropriating the bodies of the enemies and subjecting them to grievous harm. It is mainly due to the work of social psychologists and some powerful works of fiction that we have in recent years come to understand the irrationality of war. For example, work on the Vietnamese war veterans has shown how illegal operations are part of the strategy of war and the devastating psychological impact that such strategies have not only on the victims but also on the perpetrators. Many accounts of collective violence in South Asia (both the violence by the crowds and violence perpetrated on civil populations by State force in order to bring 'insurgency', 'militancy', 'terrorism'

under control) have been written by civil rights groups who have to work within a juridical model of establishing facts. They are thus concerned primarily with separating out the innocent from the guilty and naming the guilty since the governmental machinery often fails to do this. Somasundaram, on the other hand, writes not as a judge but as a physician who wants to make a therapeutic intervention. He can see the wounds suffered by the victims as well as the vanquished, but his eye also registers the brutality that was done to young persons who joined militant groups or were picked up for training in camps in other countries (in this case primarily in India). He also registers the confusion of army personnel when they have to function in a context in which military conventions have collapsed. In the case of the IPKF, they had to function in a hostile and unknown terrain in which it was not easy to distinguish who the enemies were and how civilians could be distinguished from 'militants' or 'terrorists'. That in the name of pacification, even women and children were targeted when rage and fear gave way to the 'discipline' of a legal war is the most telling commentary on the impossibility of maintaining legality in the face of the contemporary fusion of different kinds of violence. It would be easy to demonise any one category here-the militants, the terrorist, the State, the army, the Special Task Force-but Somasundaram makes us see how impossibly difficult it is to separate the perpetrators from the victims; the victims from the informers; and the informers from the military machines, in the case of any long-term chronic conditions of violence. The Indian reader will be especially interested in the analysis of the IPKF intervention, seen from the eyes of local society and not international realpolitik.

In his analysis of the Indian military intervention in Sri Lanka undertaken initially to keep the peace, Somasundaram divides the period of IPKF operations in four phases. The first covered the period after 29 July 1987 after the Indo-Lanka peace accord was signed in order to bring the ethnic strife to an end. The IPKF were airlifted into Jaffna that night while a large contingent followed. This period of entry was extended to the end of September. In Somasundaram's words 'This period...was characterised by an initial euphoria followed by suspicion, uneasiness, and mounting opposition, but with impeccable behaviour on the part of the Indian army'. It may be recalled that in their fight against the Tamil militants the Sri Lankan armed forces had earlier gained control over most of the territory outside Jaffna peninsula. India had made an intervention in the form of air drop of relief supplies despite opposition from Sri Lankan government on humanitarian grounds. The threatening postures adopted by India led to intense diplomacy that culminated in the signing of the peace accord, welcomed by the Tamils then but opposed by many Sinhalese organisations.

I need not recall all the events here but Somasundaram notes that after high power diplomacy, when the Indian ship carrying relief supplies arrived on 25 June (about a month before the signing of the peace accord) the Indian officials accompanying the supplies were greeted by huge crowds-there was garlanding and spontaneous expression of relief and joy. Some broke down in front of the Indian officials saying 'India, save us'. The misreading of signals on each side could not have been more tragic.

From October to December 1987 was the second phase, the period of Operation Pawan,[4] as the army tried to capture Jaffna from the Tamil Tigers. This is the phase characterised by Somasundaram as that of total war. It was realised by the Indian army that a task they had assumed to be simple, was fraught with many dangers due to a hostile and largely unknown terrain, guerrilla style attacks, and

the impossibility of distinguishing between the civilians, the militants, and the supporters of militants. As the army suffered numerous losses, there followed a period of violent pacification of the Jaffna peninsula. The violence of this period can be gauged by the fact that in this period something like 75 percent to 100 percent of the population of Jaffna had become refugees.

The third phase from January 1988, saw a gradual cessation of hostilities, imposition of some thing like 'normalcy' though there was the presence of the army and the imposition of martial law. Arrests, detentions, torture, ambushes, guerrilla attacks and political killings continued. The fourth and final phase was that of a war of attrition by the guerrillas in which after failing to install its own militia groups, the Indian army gradually withdrew. Bitter struggles between rival militant groups surfaced again and with the final withdrawal of the Indian army the conflict circled back with LTTE and the Sri Lankan government as the principal actors.

This is a pattern of military engagement known from many situations in which faced with an enemy that is not clearly defined, the army responds with civil reprisals. In a situation in which militants or terrorists deliberately force civilian populations into providing them with food and shelter, it becomes difficult for any army to distinguish between the civilians and the militants. The nature of violence that an army has to face in the case of an internal insurgency is not what they have been trained to recognise as the violence of warfare. Hence reason gives way to panic; instruments for 'disciplining' a population become not open warfare but torture, detention, rape. Nothing shows the irrationality of this violence better than the widespread use of rape of girls and women and murder of children. As many torture victims testified, they were tortured not because they had crucial information to give but because every time the soldiers faced unexpected violence from the militants and suffered heavy losses, they tortured the people detained as a kind of surrogate punishment. Even after the withdrawal of the IPKF the same pattern of civilian reprisals was followed by the Sri Lankan army. To that extent the distinction between an internal and external army was fuzzy indeed.

Somasundaram's book is written from the inside of the violence, as it were. That is to say, not only was he present as a witness throughout this period but his family had to flee as they became refugees. But even in these conditions of severe hardships, his colleagues from the University Psychiatry Unit of Tellipallai District Hospital and the Jaffna Medical College played a crucial role in responding to the massive social suffering. They organised medical help for those who were suffering the devastating consequences of having witnessed their loved ones killed, or tortured. In several cases men had just disappeared, leaving the survivors to live in constant uncertainty. The institutions of civil society such as hospitals or churches which sometimes provided a haven to those fleeing the violence were bombed by the armies, Indian and Sri Lankan, that successively waged wars against the militants. Sometimes institutions had to be literally invented when for instance, psychiatrists responded to an advertisement in the local newspaper that had been inserted by torture victims who were urgently in need of help by going into the community and offering psychiatric counselling. The newspaper advertisement had said that 487 ex-detainees of torture camps who were in Vavuniya had formed a group and that 80 were in need of urgent medical attention. A survey was conducted among 160 survivors (158 of the ex-detainees were men and 2 women which may point to the additional difficulties women have in seeking medical and community help). Often those who had been detained by the army and then

released were re-arrested by one or the other militant group who suspected that they may have given crucial information under torture to the army and were tortured again as punishment.

Psychiatric classifications of mental disorders are premised on certain notions of the normal and the pathological. Even in the case of a diagnostic category such as post-traumatic stress disorder (PTSD) which was invented in response to the need to capture the effects of extreme situations, the kind of cases described in this book make us seriously question whether one can think of any limits to what human beings can endure. It was common among survivors to suffer from intrusive memories of bodies, disfigurement, blood; from sights, sounds and smells of violence; of bodily mutilations; of death of children. These appeared as flashback memories in the day and disrupted sleep at night. Death scenes and battle scenes repeatedly overwhelmed survivors in the form of flashbacks and vivid hallucinations. Under such situations even the diagnosis of PTSD was not adequate and Somasundaram had to use the label of Malignant PTSD now recognised under DESNOS (Disorder of Extreme Stress Not Otherwise Specified) by the Diagnostic and Statistical Manual IV of WHO. In the traditional psychiatric vision of healing, after several phases of denial and intrusion have been repeated, the traumatic experience is worked through so that the emotional reactions are mastered and the new situation is assimilated in the psyche and given meaning. Somasundaram's case materials do not hold out the hope that the experience of extreme violence would be assimilated and given meaning by the sufferers. Instead, what these cases point to is that while the technical advances made by medicine were useless in the face of such malignant violence, the fact that medical professionals felt compelled to respond to the suffering created hope for the rebuilding of communities. For me, one of the most moving moments in the book came in the chapter specially contributed by Anna Doney on torture victims, when she recalls an account by a survivor of how the Sri Lankan security forces would compel some people from the local communities to identify terrorists. In order to avoid recognition, these 'informers' were usually made to cover their faces with sacks (with holes for the eyes to see). As one survivor stated, 'While standing in a row in this identification parade, I saw that the eyes peering through the sack were those of a woman and she was crying.' This captures the hopelessness of the situation in which low-intensity warfare plunges a society: perpetrators, victims, witnesses, informers, come from the same local worlds and have to carry on their business of surviving, informing, inflicting pain, receiving pain in the full awareness that the enemies are not out there but that each has the potential of becoming any of these.

A sign of Our Times

For philosophers like Emmanuel Levinas,[5] the events of the twentieth century are encapsulated in the idea of 'useless suffering'. 'This is the century', wrote Levinas 'that in thirty years has known two World Wars, the totalitarianism of the right and left, Hitlerism and Stalinism, Hiroshima, the Gulag, and the genocides of Auschwitz and Cambodia. This is the century which is drawing to a close in the haunting memory of the return of everything signified by these barbaric names: suffering and evil are deliberately imposed, yet no reason sets limits to the exasperation of a reason become political and detached from all ethics'. Levinas goes on to ask, 'The philosophical problem, then, which is posed by

the useless pain which appears in its fundamental malignancy across the events of the twentieth century, concerns the meaning that religiosity and the human morality of goodness can still retain after the end of theodicy' (p. 163).

Somasundaram is clearly deeply engaged with the question of the human morality of goodness and his response to the issue of useless pain is deeply philosophical though it is deceptive in its simplicity. He recommends that Sri Lankan society has suffered from too much politics. In order to restore the moral order of society he recommends that instead of being seduced by the visions of a utopian good to be attained by heroic sacrifices; instead of an ascent to the realm of the transcendental with its attendant violence, cults of martyrdom, making of history through the valorisation of death; we should consider the moral option in terms of a descent into the ordinary. This descent is the remaking of life through the nonviolent option. As he says 'Non-violence is not an all or none method and its effects, not limited by single failures can be cumulative, and build up a momentum of their own both in the spirit of the practitioners and the reaction of the opponents.'

Instead of words like humiliation, fear, panic, distrust, we need a vocabulary of the ordinary-love, agriculture, bringing up children, work, trust, laughter, domesticity, school, happiness these need to be evoked to create a new kind of sociality, to reword the world. Somasundaram reminds us that it is often not the victims, but those who speak on behalf of victims, who develop a greater stake in the violence. There needs to be a lowering of the stakes on all sides especially on the side of those who are living in other countries and sending money for women and children to be recruited to the Tamil cause in Jaffna while their own children are happily going to school: Thus, alone can the local speak up to the global.

End Notes

1. Michel Serres (1995). The Natural Contract. Translated by E. MacArthur and W. Paulson. Michigan: University of Michigan Press
2. The book also has an important chapter on the psychological after-effects of torture contributed by Anna Doney.
3. Even the variety of acronyms, LTTE, PLOTE, EROS, EPRLF, and many others, on the one side and RAW, STF on the other point to the combination of strangeness and intimacy with which language now encodes political violence.
4. The literal translation of Pawan is wind, but to my ears the tone and sound of this term evoke the wind-son Hanuman's vanquishing of the pride of Lanka.
5. Emmanuel Levinas (1993). Useless Suffering. In Dream and Existence: Michael Foucault and Ludwig Binswanger. Edited by Keith Holler. New Jersey: Humanities Press.

PREFACE

Let us call up
from the depths of our people,
all our people,
a worthy response, worthy of the best in us,
in our culture and heritage,
worthy of the best that is still to come,
that can turn back the tide
of madness and cruelty,
and restore, create, build
sanity, love and peace.

Before it is too late,
we must speak out, act, fearlessly, urgently,
and so out of the fire of fear and frenzy
create a way to sanity and peace.

-from 'Tell the People the Truth'
A collective appeal by leaders from all communities (1986)

Throughout history, the cost of war in terms of deaths, mutilation, torture, grief, destruction of material resources and property, privation and social disorganisation has been enormous. In modern times, wars have become even more destructive. The continued occurrence of war, presence of standing armies, manufacture and stockpiling of costly weapons of limitless destructive power show man's incompetence at solving his problems in peaceful ways and his struggle for power by aggression and war. Apart from the physical death and mutilating injuries, the psychological trauma of victims, survivors and perpetrators is an incredible cost of war that is least analysed. The purpose of this work is to bring out the psychological impact of war on a civilian population, using the conflict in Sri Lanka as a case study.

The framework of the study is provided by the author's own experiences of war, both as a doctor responding to the massive suffering of the people and as a person who himself became a refugee. As a member of the Tamil community my life and work in the war affected areas in Jaffna and short periods in South Sri Lanka, Trincomalee and South India, has informed many of the insights gained by direct experience of the people affected by war.

After a short background (Chapter 1) to the present conditions of war, the increasing use of repression in civil society in Sri Lanka and growing militancy (Chapter 2), the book moves towards its main focus which is the theoretical and clinical study of the psychological causes (Chapter 3) and effects (chapter 4) of continuous violence, war and widespread use of torture for securing political and ideological compliance. The psychiatric symptoms and the mental illnesses produced by the so-called civil war between the state of Sri Lanka and the Tamil militants were treated at the University Psychiatric Unit functioning in Jaffna. This provides the detailed clinical study reported in Chapter 5 of this book.

The sixth chapter covers the Indian military offensive in Jaffna which led to the author himself becoming a refugee, and then experiencing directly some of the trauma of war that he had earlier witnessed in his patients. In addition to the violence experienced by the population due to conditions of war, there was also widespread use of terror by all the political actors to secure compliance. The psychological and sociological consequences of torture described in the seventh chapter of the book, has been written by Dr. Anna Doney, a clinical psychologist, responsible for starting two counselling centres, in Jaffna and Colombo, for trauma victims of the war. The treatment and management are described in the final part of the study. The therapeutic model that has been evolved has, I hope, gone beyond the medical model of disease. In a society where violence has become chronic and its devastating psychological consequences are evident for every section of the population men, women and children, it is only by developing innovative dialogical methods that society can move towards a condition of self-cure. We are not, after all, dealing with a disease that enters the body as an alien organism, and then leaves it after running its course. We are dealing with a situation in which the conditions of violence have led to chronic feelings of fear, despair, pain and grief apart from functional impairments of a wider variety. Therefore, it is only through discussion with all sections of the population including members of militant groups, their supporters and ordinary civilians caught between the different warring groups that a new way of resolving the problems may emerge. Above all, the book is a necessary record of a turbulent period, a testimony to the agony and suffering of people caught in a war. It is to be hoped that it will encourage the Tamils, among others, to examine themselves, and pausing for a moment, reflect on what pain the society has inflicted on itself.

The discerning reader may recognise the inveterate medical habit of framing the psychological consequences of war under the traditional headings of history, aetiology, pathogenesis, clinical picture and treatment. Working with mental illness in the conditions of chronic violence however, makes us seriously question our own notions of 'normality'. The construction of reality by leaders who in their bid for power do not hesitate to use symbols such as that of sovereignty, patriotism, blood, soil, honour, nationalism, liberation, etc. to divide a people into antagonistic groups. They are more than willing to resort to intrigue, violence and even war to gain power. This in turn leads to the creation of violent individuals who can kill, maim, torture, destroy and cause untold misery. It is these so-called 'normal' individuals who may be more in need of treatment than those who come to be labelled as 'insane'. The innocuous mentally ill bear witness to the untold misery inflicted by those with driving ambition, overvalued ideas, delusions of grandeur and deep paranoia but wish to be venerated as heroes or treated as leaders by the larger society. A study such as this which records the conditions of war and chronic violence through the experiences of psychiatric morbidity, may be a better representation of the consequences of this so-called normality than the conventional studies that examine violence through means of political forces, causes and consequences.

ACKNOWLEDGMENT

Much of this work is composed of reiteration and review of existing literature, and the only justification for bringing it all under one cover, is to present a coherent whole, and weave a psychological argument that may be of benefit to our society. Most of this material may not be readily available to our lay readers, for whom it is primarily intended.

It should be mentioned that the section on identity in chapter 3 is based on Erikson's seminal work on the subject while the theoretical section on the effects of war in chapter 4 owes much to Raphael, Wilson and Horowitz. Treatment in the final section is again based on Raphael and non-violence on Sharp. Modified forms of the clinical material have been presented at seminars, appeared as papers in medical journals and chapters in books. Notably, chapters 4 and 8, as well as parts of 5,6, and 7 have appeared in the Tamil version, Mana Vadu published by the University of Jaffna. Chapters 6 mainly and parts of 8 were first presented in Broken Palmyra. Extracts from chapters 5 and 6 are contained in the chapter titled "Psychiatric Morbidity due to the War in Northern Sri Lanka" in the International Handbook of Traumatic Stress Syndromes. Many of the studies mentioned have been published in local and international journals. The study presented in chapter 7 was first presented at the Annual Sessions of the Jaffna Medical Association.

Many have contributed to the writing and preparation of this work. My co-authors in 'The Broken Palmyra' initially inspired the beginning of this work by their encouragement, its continuation by persistent pressure, and its completion with pertinent suggestions and criticism. The book was essentially written in 1988-89, in the aftermath of the IPKF war and revised subsequently. Those interested in the original, unabridged manuscript as it was in 1988-89, can find it at the library of the Refugees Study Programme, Oxford University. Dr. Rajan Hoole rewrote the section on history and edited chapter 2. A great deal is due to the patience of my mother, who provided the environment, and did the first editing and proof reading. Prof. T. Ganesvaran and Dr. A. Selvaratnam, Consultant Psychiatrist, were good enough to allow access to clinical cases under their care, and provided invaluable suggestions and advice from their clinical experience during the period of study. Dr.'s (Mrs.) S.Yoganathan, (Mrs.) Kala Sivayoganathan, (Ms.) S. Sivaranee, S. Sivashankar, S. Sivayokan and a generation of medical students together with Mr. and Mrs. Canagaratnam, and staff of the Psychiatric Unit assisted in obtaining information, statistics and in the treatment of those affected by the war. The Association of Commonwealth Universities awarded the scholarship, the University of Leeds the library facilities and Prof. A. C. P. Sims the opportunity and encouragement to complete this task, particularly the theoretical aspects presented in chapter 3. Prof. Veena Das was responsible for bringing the manuscript within a current conceptual framework by her invaluable suggestions. Malini Balasingham of the Communication Centre for Mental Health accepted the arduous task of cutting the oversized manuscript to a publishable length by her painstaking editing. The Centre for Society and Religion and Indrakanthi, supported by the UNICEF, Colombo were instrumental in transferring this onto a computer. Finally, the credit must go to Harsh Sethi and Omita Goyal of SAGE for persisting with the task, despite the prevailing difficulties and delays in communication, and bringing it out in print.

Last not least, my gratitude to my patients who were innocent victims of the war and the real source of this work. Though wishing to record my deep gratitude to all those who have assisted with this work, I wish to take complete responsibility for what follows. The opinions expressed and the descriptions of facts summoned to support them are the sole responsibility of the author. Where individuals have been mentioned critically, the reference is to their public roles as representatives of an organization or system. The effort that has been put into this work is what the author would like to offer in good faith and with all sincerity for the benefit of our society.

Reference

Collective Appeal by a Representative Cross-section of the General Public (1986) Tell the People the Truth: The Way Out of the Ethnic Conflict in Sri Lanka. Sarana Press, Dehiwala.

Free e-Book - 2025

As SAGE publications had stopped printing books, they returned copyrights of Scarred Minds. We then decided to make it available as a free e-book (but to encourage donations to Thapovanam described at the end of book). Though initially hand written in haste under the shade of a mango tree, amidst an ongoing war, during brief respites from rattling gunfire, exploding bombs, helicopter strafing, incessant shelling, deaths, injuries, displacements, and military checking; the same content and text is left unaltered despite all its shortcomings and deficiencies (though with some minor, necessary editing), in an effort to preserve the freshness of the moment, capture the mood, the immediacy, report, document, the sense of desperate urgency to stop the politico-military insanity, the pathology called war using a pen to appeal to reason, a dispatch from the front lines, reflections while mending the psychological victims of war; testimonies of human rights abuses amounting to war crimes by all parties, and a self-therapeutic ventilation (some corrections of typos and minor alterations have been done). Sadly a rare few paid with their precious lives trying nonviolently to stop the war juggernaut, but nobody listened; We have inserted local drawings, photos, cultural images, verse and poems throughout to illustrate content of each chapter, to give meaning, as an object for contemplation or meditation and as a method of catharsis towards allegorical healing[1]. Cultural images representing different faces of The universal Mother have been used in the beginning (page iii), Kali comes in her more fiercer (கோர-Kora) form as Goddess of war but she can also be loving, kind and nurturing. These more benevolent forms of The Mother are invoked towards the end of the book as Saraswathy, Mary, and Sea Goddess, portrayed in the song Boundless Benevolence ('Alaparung Karunai' Poem) . Though belonging to a subsequent period, we thought it relevant to include some material used during the post-tsunami healing work dealt with in the subsequent free e-Book Scarred Communities . These are found at the end the end of this book as both were disasters, one manmade called war and the other natural. Link to important online e-books, audios and videos are embedded in blue coloured text and can be accessed with a click.

The original MS essentially written in 1988 in the aftermath of the Indian operation, was taken out of Jaffna and later, Sri Lanka to the UK by an international peace organization due to the risky situation prevailing then (with tragic developments of the Broken Palmyra. This was a more psychologically focused sequel to that more political book). The original MS (three volumes, later abridged and cut down with help of many mentioned in the Preface to one volume for publishers) were deposited at the Oxford University library archives (still accessible) thanks to Barbara Harrell-Bond then director at Refugee Studies Centre, Oxford University introduced by Dr. Ponna Wigneraja, United Nations University. Major parts of the section on Peace in Chapter 8 was developed with guidance from Adam Curle, professor of Peace Studies, University of Bradford.

Our thanks to Dr. Judy Jeyakumar and Wanasinghe printers with their dedicated staff, T. Shankar, A. Anushan, A. Christina, S. Puvirsan for their tireless efforts in bringing out this e-book. Our gratitude to Dr. Asuvathan Aravinthan for the proofreading.

[1] Murthy, S. (2025) Spirituality and Mental Health: from Evidence to Action. Gangadhar, B.N., Roy, R., and Dhawan, A. (Eds.), Spirituality and Mental Health. Indian Psychiatric Society, Jan 2025. pp. 168-182

Chapter 1
Background

"The fault, dear Brutus, is not in our stars, but in ourselves"

Shakespeare-Julius Caesar, Act 1 Scene 11

...new bout of that raving madness called war. The same old mechanism is at work again: the inter-action of greed and fear. Lust for power or desire to dominate are barely restrained by fear-the fear of man's own vastly improved instruments of destruction. Fear, however, is not a very reliable brake on man's impulses, and it constantly poisons the atmosphere by creating a feeling of frustration which again will fuel the fires of hate.

-Nyanaponika Thera
The Heart of Buddhist Meditation

Introduction

The background to the ethnic conflict between the Sinhalese and Tamils of Sri Lanka which culminated in an undeclared civil war and ultimately resulted in an Indian intervention, is in itself an interesting and instructive psychological study. When one considers the geographical, historical, economical and religious background to the war, it soon becomes clear that the forces that are said to have shaped the conflict, completely excluded considerations of human subjectivity. By now it is quite well known that the mutual suspicion between Sinhalese and Tamils is largely due to the misrepresentation of the popular history of Sri Lanka based on myths and legends (Spencer, 1990). The crucial psychological dimension to the problem has been least understood. However, a few discerning scholars, many of them Sinhalese, have realised the importance of the psychological aspects.

The well known historian, Dr. G.C. Mendis (1963) writing more than three decades ago, had emphasised the psychological aspect:

"The Tamil problem has now developed more than all into a psychological problem. Having lost confidence in the Sinhalese in the political sphere they believe that they cannot expect just treatment from them any more. Some argue vehemently that it is quite clear that the Sinhalese are out to destroy the Tamils. Everywhere there is fear, suspicion and distrust: and this has to be cleared before any solution of the Sinhalese-Tamil problem is attempted. This fear and distrust have led to the misunderstanding of the aims and actions of the Sinhalese. The Tamils see something ominous in every Sinhalese move. It is also not surprising that what has taken place since 1956 has confirmed the fear of the Tamils. Thus, during the last forty years, what were essentially regional and economic issues have been made issues of race or language or (civic) status in order to win the support of the entire Tamil speaking people of the Northern and Eastern provinces. This is exactly what the Sinhalese-educated Buddhists did in 1956. They appealed both to race and religion to stir the Sinhalese people to activity."

Similarly, the prominent civil rights activist, the late Bishop C.L. Wickremasinghe (1985) a humanitarian intellectual deeply concerned about the ethnic conflict that was tearing the country apart, analysing the situation in 1980 saw the fundamental problem as one of differing perception: " there is a conflict of perceptions between the Tamils and Sinhalese. The Ceylon Tamils with their sense of being a national minority and the plantation Tamils with their sense of being a communal minority envisage a society where their human rights are guaranteed to them as persons and communities. The Sinhalese Buddhists in particular, with their sense of being a 'chosen people' within Sri Lanka, envisage a society in which their distinctive position as a majority with a unique ethnic culture is given due recognition."

Dr. Jehan Perera (1984) also stressed the psychological dimension in 1984, just after the traumatic 1983 ethnic riots saying, "The present state of relations between the Sinhalese and Tamil communities have their roots in historical perceptions that first arose in the dynastic wars fought by feudal rulers based on the island and neighbouring South India; in the later period of Sinhalese contraction these memories were resurrected and reinterpreted as the efforts of Hindu South Indians to absorb Buddhist Lanka; communal grievances and fears came into focus in the heady period of transition from colonial rule to self-rule; the competition for scarce economic resources and employment in the context of a stagnant economy led to the formation of communal interest groups that cut through class; government policies and communal riots institutionalised the communal divisions.

The thesis presented here is that amongst the economic, social, cultural, political and other factors that have contributed to the present explosive state of Sinhalese-Tamil relations, it is the psychological dimension of individual and communal identity that takes primacy. Identity is at the heart of communal conflict, and around it crystallise the economic, social and other grievances.

The root of communal conflict lies in differing perceptions of the Sinhalese and Tamils. The fact is that the Sinhalese and Tamils speak different languages, and have different cultures and interpretations of what happens. Thus, the victory of Dutugemunu meant the defeat of Elara; the period of Sinhalese decay in the Rajarata correspond to the rise of Tamil power in the Jaffna peninsula; the historical privileged rights of one community have smelled of discrimination of the other; democratic majorities to the Sinhalese has meant despotism of a communal majority to the Tamils; and 'terrorists' to the Sinhalese are 'boys' of the 'Tamils.'

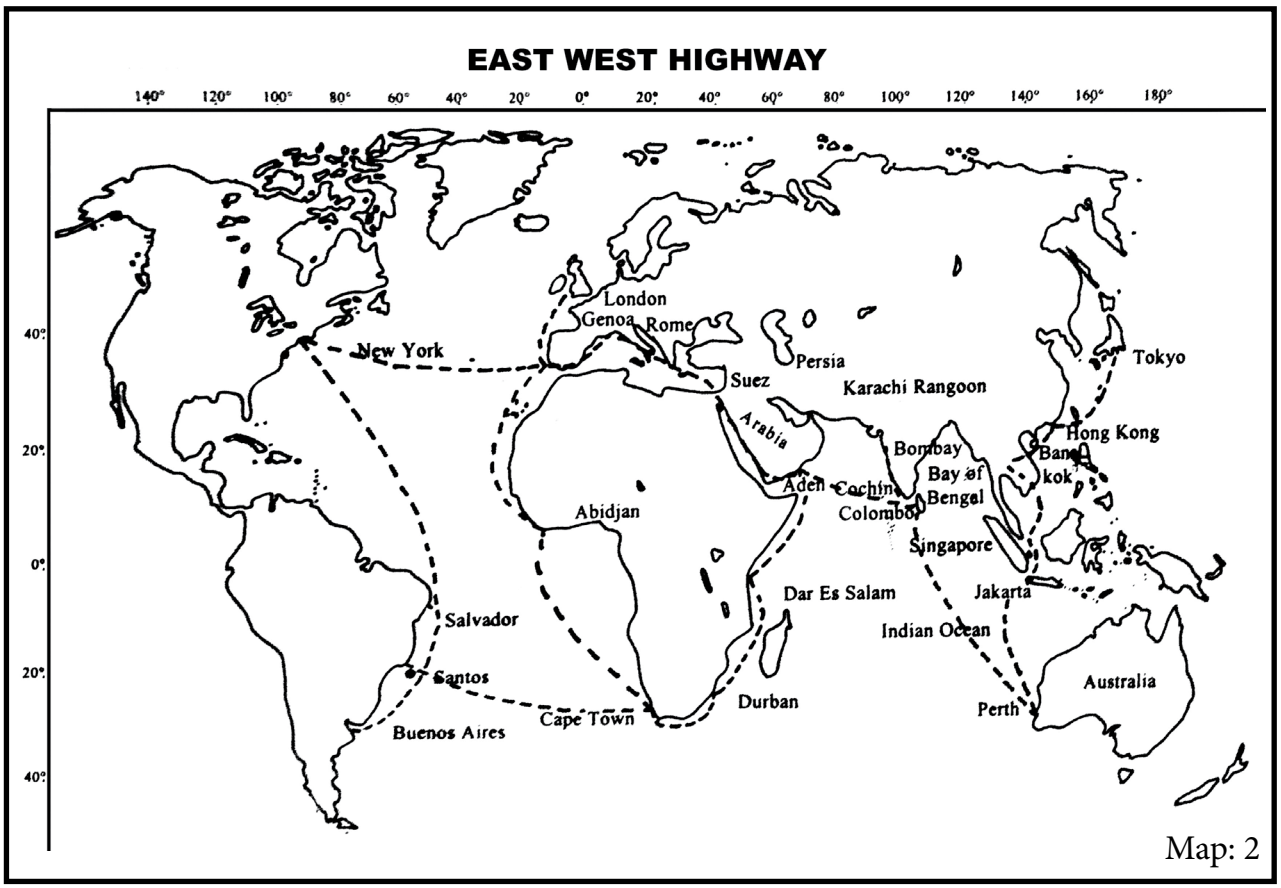
In addition to the backdrop presented here, some of the later chapters will give us some clues as to how ideologies are maintained through the everyday practices of the State. For the moment, let me give a brief description of the geographical features that are important for understanding how events in Sri Lanka have been shaped by her location and climate.

Geography

Map: 1

Sri Lanka is a small, tropical island, hanging like a tear drop off the southern tip of the Indian subcontinent. It belongs to the same continental shelf as India and was continuous with it, until land movements separated the two in recent geological times. Even today, only the narrow Palk strait, 20-30 miles in width and the Gulf of Mannar intervene between the two land masses. Shores and sand banks became established in this shallow sea bed off the North Western coast and developed into the famed pearl banks of Ceylon, renowned in the world from antiquity. The long coast line and the surrounding ocean has been a perennial resource for a large fishing community while the beautiful, coral beaches have attracted tourists from all over the world.

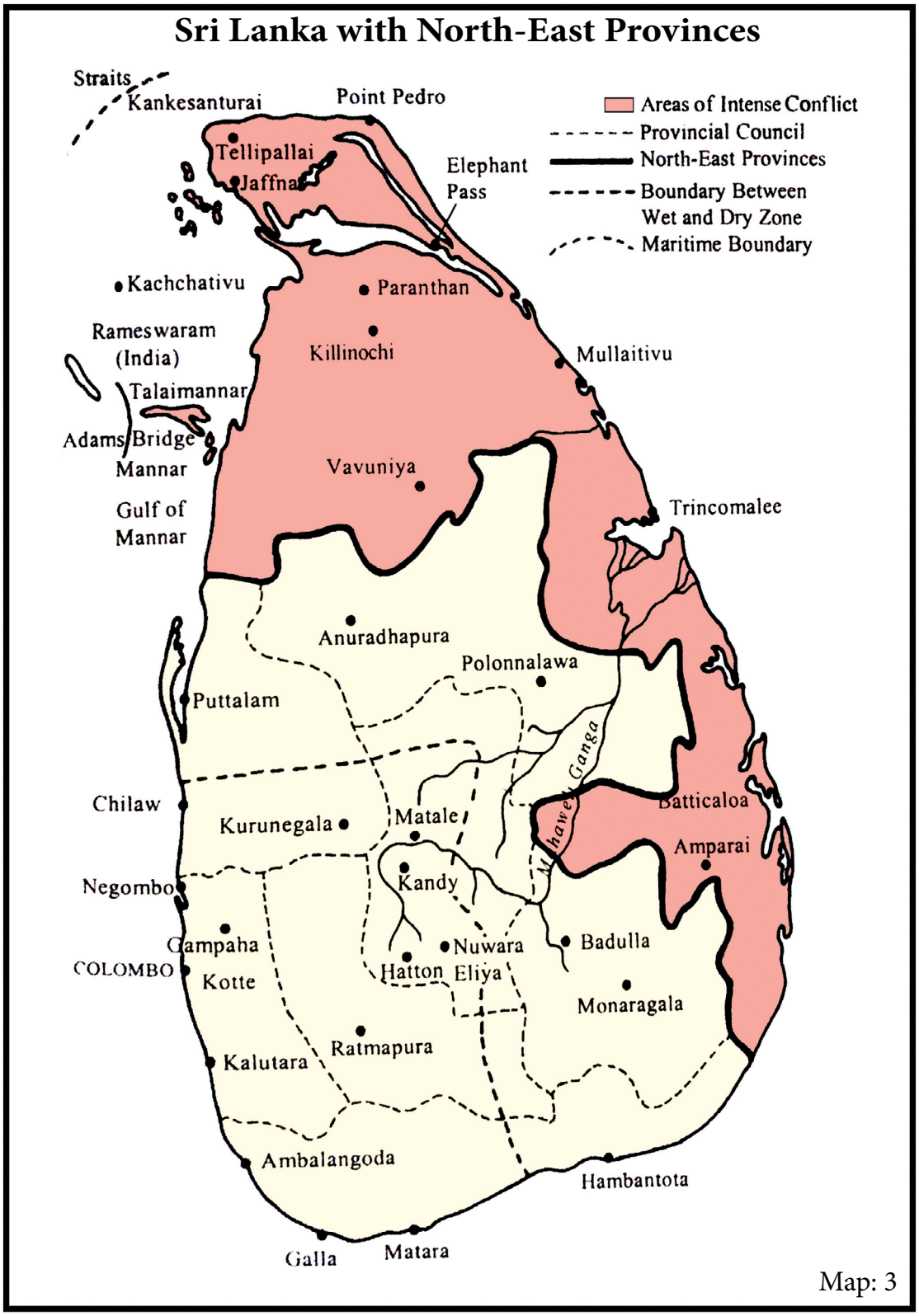
Due to its geographical location and size, India has been looking over the island's shoulder throughout its history and has been a major influence in its developments.(See Map 1) Like a mother, it has bequeathed the two major ethnic groups, Sinhalese and Tamil, that are in conflict today,-and has been the source of their religions, Buddhism and Hinduism.



Map: 2

Sri Lanka's central location in the Indian Ocean in the path of the great shipping highway from the West to the East(see Map 2), has made her an ideal stop-over harbour and trade centre. The island's wealth in gems (earning her the name Ratnadipa), spices and pearls has attracted world traders (Greeks, Romans, Arabs, Chinese, Portuguese, Dutch and British) from the beginning of recorded history. The island's strategic location,

particularly the natural harbour at Trincomalee, overlooking the Indian Ocean has attracted naval powers such as the British during their war with France and later in World War II. In modern times, Sri Lanka continues to have a strategic importance in the Indian ocean, particularly with regard to the overall security of India. These geopolitical considerations are believed to have precipitated India's recent intervention in the island (Uthayan & Vijayan, 1988)



Map: 3

The island itself can be divided into two distinct climatic zones which have some bearing in the current ethnic division.(See Map 3) The dry zone encompassing the North and East receives on the average, 50 inches of rain a year, all within the few months of the unreliable North East Monsoon towards the end and beginning of each year. It is a parched, dry, harsh land peopled mostly by the Sri Lankan Tamils. The wet zone , which is most representative of the South Western sector, receiving at most seasons of the year, through both the south-west and north-east monsoons, rainfall that is adequate or more than adequate for luxurious plant growth, typical of the tropical rain forests, is home for 'low country' Sinhalese. A third mountainous area within the wet zone in the South Central 'up-country' is occupied by the Kandyan Sinhalese, and the hill country Tamils as labour within prosperous plantations. The Muslim and other communities are found along the coastal or maritime provinces, particularly in the ports.

Within the dry zone is the North-central zone, Rajarata projected as the cradle of Sinhalese civilisation with the ancient capitals of Annuradhapura and Polonnaruwa and an extensive irrigation system which flourished during the classical period (200 BC-1200 AD). These abandoned areas are again being rapidly re-colonised by an increasingly 'Sinhalized' State (Nissan, 1996) with the repair of the old irrigation system, reconstruction and massive governmental development projects which are now being extended to Northern and Eastern provinces also. The other main principalities in the ancient period were the Ruhuna to South East and Malaya in the mountain region.

The climatic conditions of the wet and dry zones appear to have left their imprint on the character and personality of those inhabiting these areas. There is a common belief that a noticeable difference in temperament distinguishes the Sinhalese and the Tamils. Though it has proved difficult to scientifically substantiate racial stereotypes, beliefs of ethnic types may shed some light on communal perceptions and attitudes. Further, though stereotypes are invariably exaggerated and extreme, they may contain a certain germ of truth and reflect the environmental and socialisation processes that mould an individual personality. Thus, it is believed, the Tamils (Russel, 1976), facing an inhospitable climate in the North East dry zone, are a thrifty and hard working people with a degree of emotional coldness. Somewhat passive and peaceful, they make good subordinates who are most comfortable in an authoritarian system. A marked paranoid trait that makes them suspicious and clannish, has probably helped them to survive as a persecuted political minority.

By contrast, the Sinhalese, being blessed with the abundance of nature found in the wet zone, are believed to be friendly, sociable, easy going but averse to sustained toil. They

show the extremes of an emotional temperament, passionate and quick to love but equally easily aroused to anger and aggression, which nevertheless dissipates as quickly as it arose. Spontaneous and artistic, they are natural musicians, dancers and painters. The Tamils are a conservative, tightly controlled and regulated society, while the Sinhalese are more unfettered and open.

Admittedly, these stereotypes are hypothetical social constructs. The similarities between the groups far outweigh their differences, while the individual variation within each group makes it difficult to substantiate the stereotypes. An obvious example is the similarities in temperament among the women in both groups vis-à-vis the men.[1]

The inhospitable climate and consequent lack of opportunities have made the Tamils in Jaffna turn to other external occupations for a living. Thus, a good number seek white collar jobs, particularly in the public services or mercantile sector as clerks, accountants etc. outside the homeland. Great emphasis is placed on education as a means to livelihood notably in the professional fields such as medicine, engineering, law, teaching, and, more recently, accountancy. They were helped in this endeavour by educational facilities, thanks to the activities of the Christian missionaries. On the other hand, the rural folk in the south had been content to cultivate and live off the naturally fertile land or on commercial crops until recent population pressures, shortage of land and the effects of educational reforms changed social values and made them to compete for limited white collar employment. These factors set against inadequate natural resources, limited available land and a mismanaged economy led to fierce competition, resentment, frustration and finally communal violence.

Demography

One of the key problems for Sri Lanka has been the rapidly increasing population that has outstripped the limited resources and land available on the small island. The population in Sri Lanka had remained fairly stable with birth rate balancing the death rate up to the last century, and a gradual growth up to 1945. Although there was a high birth rate, the death rate was also high, due mainly to malaria, but also to infectious diseases, regular epidemics that wiped out whole villages (for example, the 1934 malaria epidemic caused 100,000 deaths), with high infant and maternal mortality. It is noteworthy that modern scientists have attributed the decline and collapse of the classical Anuradhapura

[1] If the leaders had been women as in matriarchal societies rather than men as in patriarchal societies; women would have found a more non-violent and amicable solution as they are more nurturant by nature.

and Polonnaruwa civilisations from 10th century AD and consequent migration of population southwards to the ravages of rampant malaria (Newman, 1968) and not due to invasions from South India as it has been popularly portrayed.

With the advent of Western Medicine, notably antibiotics, public health measures to prevent the spread of epidemics, and better infant and maternal care, the death rate has dropped. In Sri Lanka, the introduction of DDT in 1946 to control mosquitoes, the vector for malaria, was a momentous event as evidenced by the dramatic drop in the death rate (deaths from malaria alone dropped from 12,575 to 4,557 within one year 1946-47) and rapid growth of population as a result. This has inadvertently upset the ecological equilibrium, as there wasn't a concomitant drop in the birth rate. As early as 1949, Sir Ivor Jennings warned of the economic implications of the island's astonishing rate of population increase as "the fundamental problem of (Ceylon's) economy" (Jennings, 1949). The phenomenal growth in the population from 2.4 million in 1871 to 12.7 million in 1971 (quadrupling in 100 years), to reach 16 million in 1988 and estimated to top 20 million by the turn of the century (Dept. Of Census & Statistics, 1986), has meant a severe strain on this small island. The population density has also quadrupled in the past century, making it the second highest among agrarian countries in the developing world today (WHO, 1986). The population has been concentrated in urban areas like Colombo and the Southwest wet zone, while the Northeast had been less populated, and thus attracting the former.

A major area of ethnic conflict and one of outstanding grievances of the Tamils is the change in the demographic pattern of the Northeast by State sponsored Sinhalese colonisation. The Tamils perceive the influx of Sinhalese as a threat to the integrity of their 'traditional homeland' where they want to retain their voting majority, control over their own affairs and cultural identity, if not at least the name of their villages. The dominant Sinhalese politics on the other hand does not recognise this claim to exclusive territoriality but looks upon the whole island as belonging to the Sinhalese (Sinhaladipa). However, it is important to note that almost half of the Tamil population actually lived outside the North and East, which they claim as their homeland. The Hill country Tamils compromise 15% of the population in the central zone. However, there has been considerable internal migration following periodic anti-Tamil violence from these areas to the North and East. In addition, there has been an exodus of Tamils to India and other countries since 1983, when the civil war broke out. The exodus of the Tamil Diaspora to every part of the world (which started with the Sinhala-only policies of the State and periodic anti-Tamil violence beginning in 1956), the consequent brain drain

on the home community, the adaptation and assimilation of the migrants to the host country and the asylum issues including repatriation are burning current problems.

Attempts at family planning in Sri Lanka showed considerable progress with a drop to a 1.2% growth rate. But in recent times it has been hampered by ethnic considerations; the argument being that a particular ethnic group has to maintain its numbers in order to ensure its share of proportional representation, claims to land space, and youth to fight for the cause. Family planning programs have been implemented by the State with great fervour in some areas (e.g. Hill country), while it has meant resistance and threats to those involved (e.g. doctors) by local patriots in other areas. The population pressure in the Hill country has also been eased by the expatriation of a number of the Hill country Tamils to India as a result of continuing negotiation between the two governments and the internal migration within Sri Lanka to the Vanni due to violence and poverty. The Hill country population has actually dropped from 1,750,000 to 819,000 in 1981 (Dept. of Census and Statistics, 1986)

The social statistics of Sri Lanka show that under its expensive (35% of budget) welfare programs, its citizens have attained a high standard of health and enjoy a good quality of life, though parameters of social ill health such as poverty, unemployment, suicide, homicide, extra-judicial killings, violence, arrests , detentions, and "disappearances" have shown a marked increase. Thus, Sri Lanka, for a third world country, has one of the highest literacy rates (90%), long expectancy of life (72 years), and one of the lowest infant and maternal mortality rates. But at the same time, a quarter to half (depending on the definition of poverty) of the population is below the poverty line, the poor have become poorer, high homicide rates and the country has the highest suicide rates and number of "disappearances" in the world. From the time these figures have been available Sri Lanka has had a remarkably high suicide and homicide rate (WHO, 1986). For example in 1968, an average year that was uneventful and 'calm', she had the highest reported suicide rate of 17.2 per 100,000 and the fourth highest homicide rate (2.2) in Asia (WHO, 1986). Suicide figures have been steadily increasing to 47 per 100,000, now the highest suicide rate in the world, being most marked in 15 to 24 years age group (Kadiragamar, 1996). Thus, more than anything else, the high rates of homicide, suicide and poverty, belie the appearance of prosperity and calm of this 'island paradise' and indicated a smouldering and fostering problem within, that in actual fact had nothing to do with ethnicity.

History

Rewritten by:- DR. M.R.R.HOOLE

Modern scholarship from Sri Lanka has decisively dispelled the particular view of history as one of conflict ranging over two millennia between two monolithic ethnic groups-namely the Sinhalese and Tamils. The historical development of this country was a rich admixture of many influences-ethnic, religious, cultural, trade and migrant workers who were assimilated, forming a large variety of blends in different places and in different times (Spencer, 1990). Those whose childhood memory goes back to the early part of this century vividly remember this cultural diversity. Modern political ideologies based on selective ethno-histories have compelled ordinary people to construct for themselves 'pure' 'Aryan' and 'Dravidian' ancestries and take their place behind ideological barricades. The correct vision of history needs to dispense with kings as all powerful individuals performing historic tasks, and see them instead as more akin to modern day politicians responding to a multitude of choices and constraints imposed by their social base. Indeed in ancient times, the State lacked mass communication and the technological capability for a modern centralised administrative structure, and consequently village communities were much more autonomous.

Ancient Period

One cause for the traditional antagonistic view of history is the Pali chronicle, 'The Mahavamsa' (The great race or dynasty) which has been used to authenticate the view that Sri Lanka is sacred to the Buddhist faith and to its guardians, the Sinhalese people. But a more impartial interpretation (Social Science Association, 1985) sees a much richer history in a scholarly reading of this chronicle. The term Sinhala in the ancient sense is now believed to have referred to a dynasty favoured by Buddhist monks of the Mahavihara sect who received their patronage and to whom in turn they lent legitimacy. The chronicle itself dates back to about the 4th century AD and records events purporting to go back to about the 4th century BC (Greiger, 1964).

One event in the chronicle, which, through interpretation, has influenced modern day politics, is the epic battle between the 'Sinhalese' King Dutugemunu (Dutthagamani) and the 'Tamil' King Elara (Ellalan). Elara was a South Indian interloper who had conquered Anuradhapura, the seat of the 'Sinhalese' kings, and had ruled justly, as acknowledged by the Mahavamsa, for 44 years, giving his patronage to the Buddhist religion and organising public works such as irrigation systems. In order to avoid needless bloodshed, the elderly Elara and the young Dutugemunu agreed to decide the contest in single combat in which Elara fell. Beyond this, the Mahavamsa, obviously a selective rendering of folk memory,

reveals much between the lines. Elara was obviously held in veneration by the native people, for Dutugemunu ordered a shrine to be built for him which should be revered for all time (Obeyesekaere, 1988). This deference to a 'Tamil' king was touchingly observed by Kandyan Sinhalese aristocrats fleeing the conquering English in the early 19th century. It also reveals that there were several kings at that time and even families had divided loyalties. Significantly, South India was not an alien land in the modern sense but very much part of the political nexus if not part of the extended family.

The Mahavamsa itself reveals that from the oldest times wives for kings and other prominent persons and artisans had been brought regularly from South India. In as late as the 19th century Kandyan Sinhalese aristocrats found in the Tamil regions and South India, a natural refuge. The Mahavamsa was thus a document compiled by a Buddhist sect that had become and was to remain a kind of established church to cement a symbiotic relationship between itself and its royal patrons. In this sense it was a unique source of historical material in the whole Indian subcontinent and has been useful in dating events in India as well. The only other documented sources of history pertaining to the Indian subcontinent (and Ceylon) mainly come from accounts of travelers such as the Greeks, the Chinese Buddhist scholars Fa Hian and Tsuan Sang in about the middle of the first millennium BC, Marco Polo the Italian, followed by those from the Islamic world, and then the Europeans. Other sources are mainly inscriptions that are still being uncovered by archaeologists. These inscriptions mainly record gifts to religious bodies and to public charities and civil works. Inscriptions in an older form of Tamil and written in the script dating back to about the 2nd century BC, have been discovered. Tamil was then in its pre-classical form and a form of Sinhalese if it existed was probably no more than a spoken language.

All evidence points to Sri Lanka, then, as part of the loose South Indian polity with no strong dividing lines. The ancestors of the present day Sinhalese and Tamils were essentially from the same stock, were generally dark complexioned [the social bias towards light skin being a post European colonial phenomenon (Gunawardena, 1994)] with language, religion and written scripts having no particular links with ethnic consciousness, and with the original autochthonous inhabitants being progressively assimilated by the new arrivals. It is noteworthy that remnants of the authentic 'sons of the soil', the Veddahs are now facing extinction due to multinational development and encroachments on their traditional lands. As regards religion, Hindu temples, co-existed with Buddhist temples throughout Sri Lanka as in South India, and people approached different gods for different needs. This is still evidenced by the Hindu shrines in Southern Sri Lanka that are integral to the practice of Buddhism.

We now confine this sketch to an outline that would help us understand the growth of 20th century ethnic consciousness.

The kingdom of Anuradhapura, renowned for its monumental irrigation works and tanks, was in decline by the 10th century AD. Parts of the unused irrigation system became a breeding ground for mosquitoes causing the rapid spread of malaria. Up to this time there had been waves of migrants from South India and much intercourse in the way of religion, personal contact and transfer of technology. Buddhism was flourishing alongside Jainism throughout South India and both were being effectively used as vehicles for protest by social outcasts against a hierarchical Brahminism. It is notable that Tsuan Sang records that during a time of civil unrest in Ceylon during the 7th century, Buddhist scholars from Ceylon took refuge with their colleagues at the Buddhist University at Kailarapuram in South India. During this period great Buddhist and Jain works had been written in Tamil.

Several things happened during this period, the 10th century, which left their mark on the development of a Sinhalese identity. With the growth of militant Hinduism in South India, Buddhists and Jains were persecuted to the point of near extinction by about the 14th century. Some of the persecution appears to have been violent. The Chola empire extended to Sri Lanka in 970 AD. Though the Cholas are said to have been militant Hindus, they were in practice pragmatic. During their 70-year rule in Sri Lanka, they continued the tradition of civil works and extended their patronage to Buddhism. However, Buddhism in Sri Lanka would have found itself more isolated. There was thus a logical need to incorporate greater numbers into the Sinhalese identity as the natural guardians of Buddhism. The transition of the word Sinhalese from a dynastic term to an ethnic term was underway (Gunawardene, 1994).

Parakramabahu 1 revived the fortunes of 'Sinhalese' power at Polonnaruwa. The old traditions of intercourse with South India were continued and Hindu Gods were venerated alongside Buddhist worship. It has been said that 16 out of 25 of Parakramabahu's ancestors can be traced to the Tamil country in India. His expensive foreign adventures economically crippled the kingdom. Parakramabahu is said to have been the first king whose suzerainty was acknowledged throughout Sri Lanka and the last until George the IVth of Britain. Modern Sri Lankan heads of state, too, like to compare themselves with Parakramabahu without acknowledging his Tamil ancestry and the crippling economic cost of trying to unite the country by violent means. With the decline of Polonnaruwa, at least three kingdoms became prominent. One was the kingdom of Jaffna in the North, Kandy in the Hill Country and Kotte another prominent kingdom in the South. They all fought their dynastic wars, often seeking help from South India. A new wave of

migrants from South India included among others a large number of mercenary soldiers. They were given every incentive for assimilation such as lands and marriage to local women. Their descendants are the enterprising Karawas.

The next momentous development was the arrival of Europeans. First the Portuguese from 1505-1656 and then the Dutch from 1656-1796. During these two periods the Kandyan kingdom which held out in the central hills remained a bastion of local resistance. During the Portuguese period there was extensive and at times, forceful, missionary activity; a large number of persons along coastal areas converted to Roman Catholic Christianity and mission schools providing education in the local languages were established. Both the Portuguese and the Dutch brought in labourers from South India to work the cinnamon plantations. Their descendants were assimilated by the Sinhalese as the Salagama caste. The Dutch introduced the Roman-Dutch Law and were mainly commercial in their outlook. Though insisting on nominal conversion to Dutch Reformed Christianity as a condition for transacting legal business, the Dutch East India company was unwilling to spend no more than the minimum on maintaining pastoral care. It is a tribute to the work of Roman Catholic missionaries that their church survived as an underground church under Dutch persecution, while in contrast, the Dutch Reformed Church collapsed upon the arrival of the British.

The British arrived in 1796. Their principal interest then, a time of war, was the natural harbour of Trincomalee, to secure control over the empire in India and the Far East. By 1813 they captured the Kandyan kingdom then under Tamil Nayyakar rule and controlled the whole country. Two rebellions centred in Kandy erupted in 1818 and 1848, both ruthlessly put down. The second arose from moves to increase the tax burden on the peasantry during a time of economic depression, while easing the burden on coffee plantations. Ironically those in the forefront of the anti-imperialist struggle were pushed out of the mainstream of history, mainly to the East, while interlopers and collaborators who co-operated with the British gained ascendancy and their descendants are the present day elite rulers.

Modern Period

With the Napoleonic wars ended, the British gave their minds to developing the economy as a profitable venture. The Colebrooke Commission Report of 1832 recommended a set of reforms. The educational reforms transplanted the English public school system in to this country to supersede vernacular education. This gave rise to a local elite able to take part in commerce, administration, the professions and realise a vested interest

in the British Empire. By 1865 tea had very successfully replaced coffee as the prime export crop. A new wave of Indian Tamil migrants were brought in to provide a regimented labour force on the plantations.

While Jaffna which had received American Missionary education from 1812 sent many aspirants into the government services; many low country Sinhalese entrepreneurs, mainly the Karawas, carved for themselves a considerable niche in the commerce of the plantation economy. In turn, members of this successful elite funded a Buddhist revival. Many of the Sinhalese Buddhist elite also became enamoured with the then, European notions of race, believing themselves that Sinhalese were part of the Aryan race. This was owing to the work of some scholars like Max Muller who classified Sinhalese as an Aryan language (Gunawardene, 1994). However, at this point there was no conflict of interests between the Sinhalese and Tamil elite.

Under the economic freedom enjoyed within the British empire many outsiders, particularly from India, established themselves in the commerce of this country. The low country Sinhalese elite who were both in commerce as well as in politics began to feel the pinch. The first burst of Sinhalese chauvinism was against these minorities successful in commerce. Anagarika Dharmapala, a Buddhist reformer from the low country commercial class started raising the cry of the land as sacred to Buddhism to hit out at these successful minorities, who were supposed to be polluting this land. The plantation Tamils who had no political organisation and did not pose a threat to this elite were not generally attacked. But there were disturbing implications for the future.

In the 1920's, a large number of Indian Tamils were in the lower ranks of the government service. In the late 20's Indian and Sinhalese workers joined in a series of successful strikes, i.e. the Colombo harbour and the tram ways-under the leadership of A. E. Goonesinha and Nadesa Iyer. The local elite, who were discussing the Donoughmore reforms, took alarm at the prospect of political rights to workers of Indian origin. The Donoughmore Constitution of 1931 brought in several members elected on the worker vote. Furthermore, the depression of the 30's and the resulting unemployment problems gave rise to resentment against Indian workers in urban areas. This resentment took the form of a virulent campaign against Indian workers. However, while re-trenching the Indian workers in the urban sectors, the government did continue to bring in Indian workers for the plantation sector. The Indian workers also found new champions, in the left led by Drs. N.M. Perera and Colvin R. De Silva. The outbreak of World War II gave the plantations an economic importance. With 'symbolic' leadership from the left, they demonstrated their power in a series of successful strikes for better conditions in 1939/40, further alarming the British and the local elite.

When independence was given on a silver platter to Ceylon in 1948 under the Soulbury constitution, the definition of citizenship was left open. This 'deliberate omission' is believed to be the result of an understanding between the local elite and British interests. Soon after independence, citizenship was defined by a simple majority vote in the parliament and the Tamil plantation workers, forming 12% of the population, were rendered a captive labour force without citizenship or political rights. Ironically, some of the worst enemies of these workers were the descendants of Tamil mercenaries and cinnamon plantation workers who had arrived from India between 600 and 200 years ago, and who now formed about 40% of the 'Sinhalese' population, and were spearheading the Sinhalese-Buddhist chauvinist movement with claims of purity and exclusiveness.

The disenfranchisement of Indian plantation workers with the collusion of a large section of the Ceylon Tamil elite in the face of strong opposition from the Sinhalese left, had two far-reaching consequences: it substantially reduced minority representation in parliament, and eliminated the left as a serious contender for political power. This opened the field to Sinhalese communal and right wing politics.

Universal free education had been introduced in 1943. By the mid 50's with no corresponding economic development, there was strong competition for limited government jobs. Just as the ideological thrust of Sinhalese chauvinism was first turned against Muslims just before 1920, then against Indian workers occupying labourers' positions in government departments in the 30's, followed by a reaction against Christian influence, it was now increasingly turned against educated Ceylon Tamil white collar aspirants. Although the Sinhalese and Tamils were both led by the small English educated elite and their conflict of interests did not involve the peasant masses, in order to mobilise electoral support, both found themselves raising communal slogans to get others, at least emotionally, involved.

The next landmark in the communalisation of politics after the Citizenship Act on 1948 was the Sinhala Only Act of 1956 brought in by the new SLFP government of S.W.R.D. Bandaranaike which had replaced the UNP government on that promise. With mounting Tamil opposition and realising the inherent dangers, Bandaranaike had discussions with S.J.V Chelvanayakam of the (Tamil) Federal Party and signed a pact in 1957 which provided recognition for the Tamil language and substantial devolution to the Tamil areas. This was then abrogated when the UNP leader J.R. Jayawardene mobilised chauvinist sentiment against this pact in a march to the sacred city of Kandy. The 1958 anti-Tamil violence followed. In the course of such bouts of violence, top national leaders gave voice to sentiments as though they too had become infected by the frenzy of the mobs (Vittachi, 1958).

Deprived of numerical strength to realise power on its own, the left went in to coalition politics in the 60's indulging in some of the worst communal mudslinging. The first republican constitution brought in by Mrs. Bandaranaike's left coalition of 1972 legally enshrined the Sinhalese Buddhist character of the State.

The UNP government of J.R Jayawardena, after having promised much to the minorities and having been elected with their support, started its term with the anti-Tamil violence of August 1977 in which UNP elements were joined by others, leaving about 400 Tamil dead. The UNP government got lost in a process of unprecedented corruption and open economic policies which were impoverishing the masses. Strong repressive measures resulted in a growing popular Tamil militancy, more strident demands for Tamil autonomy, worker unrest, increasing state terror and a diversion of anger against Tamils for ills having a different provenance. The President himself and several ministers in the government indulged in free lancing ideological forays presenting the Tamils as essentially evil. Further anti-Tamil violence occurred in 1981 to be followed by the worst attacks in July 1983 (Piyadasa, 1984). Many of the victims of the latter were Tamils of Indian origin whose party, the CWC, was a member of the government and had in December 1982 helped Jayawardena to extend the term of parliament by a referendum. About 3000 Tamils died in these attacks, while most of their property was destroyed. The complicity of the State in the holocaust was an international scandal which brought in India as an arbiter in Sri Lanka's affairs-a long expressed fear of Sinhalese chauvinists which they helped to fulfil.

By now an equally pernicious and counter ideology of Tamil chauvinism had become militarised, displacing its parliamentary progenitors, the Tamil Untied Liberation Front, with covert Indian help for this cause. The Sinhala leadership, for their part, also marginalized and effectively banished the Tamil moderate leadership through parliamentary and extra parliamentary actions, thereby opening the door for the militant leadership to take over. The Sinhalese and Tamils, divided by ideology rather than by origins, were set to spill each others' blood in addition to their own, in a long and costly civil war.

Economy

On the economic front, Sri Lanka started on a good footing as an independent nation in 1948. A strong sterling balance following World War II, favourable world trade for its principal commodities-tea, rubber, coconut-and a literate, healthy population augured well for the future. But successive governments failed to capitalise on this good start, and it has been a steady downhill course, with a tendency to make a scapegoat of the

Tamil as the cause of all the ills that have befallen the country.

Essentially, Ceylon failed to diversify its economy and maintain a sustained balanced growth to keep pace with its rapidly increasing population. The population grew due to a high standard of health and soon outstripped the available natural resources and cultivable land. Consequently there was chronic unemployment (particularly among vociferous educated youth), landless disgruntled peasants, galloping inflation and increasing pauperisation of the poor. The poor have actually grown poorer and the rich richer (Norad, 1988). About 40% of the population is described as being below the absolute poverty line (Regional Centre for Strategic Studies (RCSS), 1996).

Due to the population explosion and the consequent lack of land and opportunities for educated youth, there has been a large scale migration of the population from the villages to the city, seeking employment, creating a politically volatile rootless lumpen proletariat in the city slums and ghettos. Patronage, nepotism, and corruption with mudalalis and goondas have largely characterised the working of the establishment (Thambiah, 1986). Close ties with the criminal underworld, as well as with sinister extra-judicial units have become routine for politicians holding high office.

Thus, increasing poverty, frustrating unemployment and diminishing natural resources (particularly land), compounded by a mismanaged economy, exposure to unattainable luxury goods and unrealistic expectations of prosperity, are the economic determinants of the continuing youth unrest and violence, specially the JVP phenomena in the South.

Sri Lanka has generally had a mixed economy with a mixture of capitalist and socialist forms, the emphasis shifting with the government (UNP and SLFP) in power. To a large extent, vote-conscious governments have been committed to high welfare spending, consuming 35-40% of the budget on free education, health, and rations or food subsidy, and other social welfare services. An attempt to cut down on welfare(usually owing to World Bank or IMF pressure) has spelt disaster for the government in power, as for Dudley Senanayake in 1952 and 1970. It has also meant large expenditure on state ventures where party supporters and, under majoritarian politics, one ethnic group find employment. The State has gradually increased its involvement and control in all aspects of national life, a phenomena referred to as 'statism' (Balakrishnan, 1992) further compounded by 'Sinhalization' of the State (Nissan, 1996) This was particularly seen in land ownership, allotment and development programmes.

With the introduction of the free economy system by the previous UNP regime, social inequalities have increased. Jayawardene made changes with slogan of modernising the economy along Singaporean lines and accelerated development to make the 'great leap forward' into Newly Industrialised Country (NIC) status. Such schemes as the Free

Trade zone, Accelerated Mahaveli Programme, tourism and encouragement of foreign investment were started with great expectations, financed by liberal Western aid. Foreign employment opportunities, particularly of maids in the Middle East brought considerable foreign earnings. It also saw the unprecedented encroachment by multi nationals, especially Japanese and Indian, marginalization of the poor and indigenous populations and increasing dependence on biotechnology in agriculture.

But the pre-occupation with an ethnic conflict, the soaring expenditure and ravages of war were to ruin the country's economy. The increasing militarization of the whole country has seen a soaring defense budget expenditure which has now officially reached 44 billion rupees (US$754 million), more than on health and education combined, accounting for 22 percent of government spending. But this may be only the 'official' tip of the iceberg compared to what is actually spent. Under other funds, votes and other resources, for example foreign aid and loans for development and rehabilitation, have been increasingly unofficially diverted towards military objectives. Thus, the whole Accelerated Mahaveli Programme, especially the Manal Aru or Weli Oya scheme (UTHR-J, 1994), are part of the State's overall military strategy and heavily funded by foreign governments and agencies. The extensive colonisation schemes in the North and East have not only completely funded Sinhala settlements, but also created the infrastructure to service them. Rehabilitation funds and material also have found their way into the military effort or have favoured an ethnic group. Just as a simple illustration, the blue UNHCR tents for refugees are widely used in army camps, as well as drilling for tube wells for resettlement programmes also extends to adjacent military camps. This has been true of other state sector expenditure too, not accounted for under the official Defense allocation and almost completely funded by foreign aid. The total external debt stands at $6.4 billion (RCSS, 1996). The peace dividend, if and when it comes, will be very high indeed. But, then these vested interests, investments and structures will have to be reversed.

Since 1956 there has been growing discrimination against the Tamils in a bid at 'assertive action' to redress perceived imbalances. This has led to 'over correction' whereby the Sinhala majority now enjoys a gross advantage in university admissions particularly to the important fields of medicine, engineering and law, employment in the public and private sectors, recruitment into the armed forces and administrative posts (Table I & Table II). In terms of economic expenditure in Tamil areas, taking Jaffna district as an example: "Jaffna district has 5.6% of the country's population. In the case of the general budget, an analysis of the figures in the Ministry of Plan Implementation Performance, 1981, shows that capital expenditure on the Jaffna district was only Rs. 260 million. That

is only 2.6% of the national capital expenditure of nine billion rupees. The per capita expenditure in the Jaffna District is Rs. 313, while the national per capita expenditure is Rs. 656. In addition, foreign aid utilisation in the Jaffna District for the period 1977-82 was nil" (Report of the Committee for Rational Development(RCRD), 1984). Similarly, the Integrated Rural Development Program (IRDP) funded by the World Bank, NORAD and the Dutch government invested almost Rs.2 billion in developing several districts in the South from 1979-82 while no projects were implemented in Tamil districts until 1984, when Mannar and Vavuniya were included (Manogaran, 1987)

Analysis of bank figures also show that the traditional Tamil habit of thrift and saving has led to a siphoning off of monetary assets from Tamil areas to the centre (RCRD, 1984). In terms of unemployment rates, 41% of young Tamil males who have passed the GCE A/L examinations are unemployed in comparison to 29% for Sinhalese youth (RCRD, 1984). In terms of land allotment and colonisation schemes, there has been a concerted effort by the State to develop and settle areas of the North and East with largely Sinhalese peasants for example the Gal Oya, Master Plan and Accelerated Mahaveli programmes. As the ethnic conflict progressed, Tamil villagers were to be driven out and replaced by Sinhalese settlers as in Trincomalee and Manal aru (University Teachers for Human Rights-Jaffna (UTHR-J), 1994).

Tamils thus perceive themselves as a besieged minority who are being squeezed economically. This has in turn led to the 'separatist response' where Tamils demand the right to control or determine their own economic development and destiny. However, the ethnic war brought all economic development in the North and East to a complete halt. More, it has led to the utter devastation of the land, buildings, institutions, resources and property; contamination with landmines and large scale displacements that makes the North and East look today like ancient ruins of some long lost civilization. The contrast with the South, where modern developments have kept pace with the rest of the world, for example in technology, communications, media, electronics and so on, is striking. The North and East have gone backward to no electricity and bicycles. The war also has given the state the opportunity to push ahead with its colonisation schemes with extra vigour and protect it with the army as well.

Table I
Employment of Tamil Minorities (from Nissan, 1996)

Ethnic group	% of population	% in state service	% in provincial services	% in semi-government service
Sri Lankan Tamils	12.7	5.9	7.1	8.2
Hill Country Tamils	5.5	0.1	0.2	0.5
Muslims	7.37	2.0	4.2	1.0
Total	25.6	8.0	11.3	9.7

Table II

Changes in the Ethnic composition of Candidates Admitted to the Different Faculties in Sri Lankan Universities between 1970 and 1983

Percentages of Sinhalese and Tamils (Tamils in parentheses) (from Manogaran, 1987)

Year	Arts	Physical, Biological Architecture	Engineering	Medicine and Dental	Agriculture and Veterinary	Law
1970	98.1 (6.9)	69.7 (27.6)	51.7 (48.3)	49.2 (48.0)	39.2 (53.6)	57.7 (34.6)
1971	89.7 (7.0)	68.0 (28.6)	55.9 (40.8)	51.7 (43.0)	59.4 (34.4)	54.2 (33.4)
1972	92.7 (4.7)	67.0 (31.2)	62.4 (34.7)	53.7 (41.8)	59.6 (38.5)	85.8 (10.2)
1973	91.8 (5.9)	73.1 (23.6)	73.1 (24.4)	57.5 (38.4)	54.9 (42.2)	77.3 (18.1)
1974	86.0 (10.0)	75.1 (22.0)	78.8 (16.3)	69.9 (26.2)	80.9 (15.2)	--
1981	82.8 (13.3)	63.5 (31.8)	67.2 (28.1)	72.7 (23.1)	--	73.0 (16.0)
1983	77.1 (16.4)	73.4 (23.1)	66.4 (28.1)	72.8 (22.1)	--	78.1 (11.5)

The blatant non-investment in industrial projects in Tamil areas has been one of the bitter criticisms of the successive Sinhalese governments made by Tamils. But as industrial societies are belatedly finding out, the long term consequences of unrestrained industrialisation to the ecology, physical and psychological health, economy and quality of life can be detrimental. For example, of the few industries developed in the North and East, the Cement Factory at Kankesunthurai takes pride of place for providing wages to local workers in addition to being one of the only profitable and efficient ventures in the state sector for the whole island. Yet, Tamils fail to appreciate what the factory has meant in terms of destruction of all the surrounding farmland due to its toxic exhaust, the emigration of the local population the export of valuable natural resource without local recompense, excavation of huge pits with the ever-present danger of salinity of the water table-in short, on deeper analysis, the Cement Factory turns out to be a good example of the type of blind exploitation happening in third world countries. The questions of industrialisation, technological development and progress have to be approached cautiously with due appreciation for the long term ecological and social costs. In the final analysis, the ill intended non-development of the North and East may have been a blessing in disguise.

Religion

Dr. Uyangoda (1988) states the current problem facing Buddhism (as well as the other religions practised on this island) very succinctly: "The ethnic war in recent years has indeed produced a deep crisis in the Theravada Buddhist culture in Sri Lanka. To put this crisis in rather crude terms, violence and death, in its most cold blooded form has engulfed a land where the teachings of the compassionate Buddha are supposed to guide the individual as well as social life. Has contemporary Sri Lankan Buddhism seriously addressed itself to this cruel and unfortunate paradox".

Professor Mahinda Palihawadana (1983), of the University of Sri Jayawardenapura has this say about 'violence in a Buddhist society': "If you are a Buddhist, you will not kill. If you can kill a human being, you must count yourself out as a Buddhist. So, being Buddhist puts you right away from the path violence. Let us call this the Buddhist mind.

The Buddha asked us first and foremost to be awake to what we are. He asked us not to kill. But, first and foremost, he asked us to be aware that we have in us the propensity to kill, the mentality of hate and retaliation. This is what enables us to be provoked. Awareness is the cornerstone of the Buddhist teaching, the Dhammapada Commentary says that Buddha's entire teaching can be summed up in one word, the word awareness. Awareness develops this critical faculty. It liberates man from the influence of myths, including the myth of radicalism.

If 'Sinhala Buddhism' can deter us from being merciful, then it is not a form of Buddhism.

Let us be aware of the seeds of hate and retaliation in our society. Then at least we would have taken the first steps in our pilgrimage towards the Buddha."

The problem facing all religions on the island becomes immediately clear if we realise that we are dealing with a social institution that has become divorced over the years from the basic teaching and intentions of the original founder.

This is not to deny that there is no true spirituality or genuine Buddhists on the island. Perhaps true Buddhists would be leading quiet, simple, unobtrusive and compassionate lives, 'far from the maddening crowd'. One can meet dedicated selfless Buddhist monks working for the good of the common man, Sinhala or Tamil, who don't have a trace of violence or racism in their minds. The former incumbent at KKS, Rev. Padma Siri Thero and Rev. Siambalagama Thero of Vavuniya immediately come to mind.

One hears of saintly sages who have retreated into the forests around Kandy or Kataragama. Unfortunately for Sri Lanka these redeeming humanitarian and spiritual elements have

been completely submerged by more vociferous, militant and chauvinistic agitators in the name of religion. It is reassuring to learn that the extreme violence that erupted within Sinhala society during the recent election campaign towards the end of 1988 and the beginning of 1989 has alienated a section of the Buddhist Sangha who have voiced their opposition to violence and come out in strong support of Ahimsa.

For Sri Lanka Tamils the spiritual aspects of the religions have long since disappeared from their consciousness. Hinduism as it exists today is an institutionalised ritualism, that has lost touch with the true spirit of Siva Siddhantam and the perennial Sanatana Dharma.

Is it any wonder that Tamil youth have no patience for a religion that to them borders on commercialism, materialistic contracts, superstition and meaningless ritual? Thus, Hinduism does not play an important role in Tamil identity or the ethnic conflict as does Buddhism. It is the Tamil language that is the crucial issue for the Tamils, and religion comes in as an appendage of the whole Tamil culture.

Unfortunately, the Christian churches too have also largely divided along ethnic lines. As Christianity straddled both ethnic groups, church leaders and the Christian community could have played a constructive role in bringing the two groups together. This was not to be as language and 'ethnicity' proved stronger than religion. Few, like the late Bishop Wickremasinghe, were an exception rather than the rule. In contrast, Muslim religious leaders, Moulavis and Mosques organizations, have played a more subdued, if not a constructive role, particularly in the East where they have tried to bring the communities together.

The greatest tragedy that has befallen Sri Lanka is the singular lack of true spiritual men, who genuinely practice the teachings of their respective religion, to guide and lead the people through this crisis. What she needs more than anything else is an emissary like Mahinda. If he could only appear in these troubled times and hold up his hand for peace as he did centuries ago. Perhaps more important, there will have to be a Devanampiya Tissa here, who is both receptive and could understand the message of Ahimsa and compassion.

Reference

1. Balakrishnan, N. (1992) Statism. Memorial Lecture, University of Jaffna, Jaffna.
2. Department of Census and Statistics (1986) Statistical Pocket Book of the Democratic Socialist Republic of Sri Lanka. Department of Census and Statistics, Colombo, Sri Lanka.
3. Greiger, W.(trans) (1964) The Mahavamsa. Pali Text Society, Luzac and Company Ltd., London.
4. Gunawardena, R.A.L.H. (1994) The People of the Lion: the Sinhala Identity and ideology in History and Historiography In Spencer, J. (ed.) ibid.
5. Jennings, W.I. (1949) The Economy of Ceylon, London.
6. Kadiragamar, L. (1996) Mental Health in Sri Lanka. Keynote Address for the National Council for Mental Health, Colombo.
7. Manogaran, C. (1987) Ethics of Conflict and Reconstruction Sri Lanka. University of Hawaii Press, Honolulu.
8. Mendis, G.C. (1963) Ceylon Today and Yesterday. The Associated Newspapers of Ceylon Ltd., Lake House, Colombo.
9. Newman, P. (1968) Malaria Eradication and Population Growth. School of Public Health, University of Michigan, USA.
10. Nissan, E. (1996) Sri Lanka: A Bitter Harvest. Minority Rights Group, London.
11. Norad Report (1988) Growth Strategy and Sri Lanka's Poor. Lanka Guardian, Vol. II No.3, Colombo.
12. Obeyesekere, G. (1988) A Meditation on Conscience. Social Scientists' Association of Sri Lanka, Colombo.
13. Palihawadana, M. (1983) Violence in A Buddhist Society. Weekend, Sept 11,1983. Colombo.
14. Perera, J. (1984) The Significance of Communal Identity. The Island (15.4.1984). Colombo.
15. Piyadasa, L. (1984) Sri Lanka, The Holocaust and After. Marram Books, London.

16. Regional Centre for Strategic Studies (1996) Newsletter, RCSS, Colombo

17. Report of the Committee for National Development (1984) Sri Lanka: Ethnic Conflict, Navrang, New Delhi. (Statistics taken from Ministry of Plan Implementation Performance (1981), Central Bank Review of the economy (1981) & Government Budget Estimates (1981))

18. Russel, J. (1976) The Ceylon Tamils Under the Donoughmore Constitution. Ph.D. Thesis, University of Peradeniya.

19. Social Scientist Association (1985) Ethnicity and Social Change in Sri Lanka. SSA, Colombo.

20. Spencer, J. (editor) (1990) Sri Lanka: History and the Roots of Conflict. Routledge, London,

21. Thambiah, S.J. (1986) Ethnic Fratricide and the Dismantling of Democracy. University of Chicago Press, Chicago.

22. University Teachers for Human Rights-Jaffna (1994) From Manal Aru to Weli Oya. UTHR-J, Jaffna.

23. Uthayan & Vijayan (1988) Sri Lanka's Ethnic problem in the Indian Ocean region. Rosa Luxemburgh Educational Circle Publication, Madras.

24. Uyangoda, J. (1988) Dharamasiri Bandaranayake's 'Echoes of War': Peace, Please. Lanka Guardian, Vol.10 No.23, Colombo.

25. Vittachi, T. (1958) Emergency '58. Andre Deutch, London.

26. Wickremasinghe, C.L.(Rt. Rev.) (1985) in The Gospel in the World, ed. Ambalavanar, D.J.(Rt. Rev.) Christian Literature Society, Madras.

Chapter 2

The War Years (1983-1997)

Ah, love, let us be true
To one another! for the world , which seems
To lie before us like a land of dreams,
So various, so beautiful, so new,
Hath really neither joy, nor love, nor light,
Nor certitude, nor peace, nor help for pain ;
And we are here as on a darkling plain
Swept with confused alarms of struggle and flight,
Where ignorant armies clash by night.

-Matthew Arnold

Introduction

As wars go, the Sri Lankan guerrilla, ethnic, Eelam or civil war as it has been variously called, perhaps never reached the degree or intensity of a conventional battle. It was more a chronic, periodic 'low intensity conflict' punctuated with guerrilla attacks, followed by civilian reprisals. There were occasional acute phases of a total war situation when the army went all out to capture an area, such as 'Operation Liberation' to capture Vadamarachi or 'Operation Pawan' and 'Operation Rivirasa' to capture Jaffna. Limited offensives were much more common, as when the forces surrounded a suspected militant camp, for example Kokadichcholai, or made a determined effort to break out of besieged camps, for example in Jaffna in June 1986, or when the militants in their turn attacked a police station or army camp. Nevertheless, incidents continued to happen daily-shootings, land mine explosions, an ambush, heavy shelling or a bombing raid-and there was invariably a daily toll on civilians. People learned to live in fear and cope with the violence that became pervasive.

In the General hospital where I worked, Consultants doing their daily round would

momentarily pause to look at the ward where a shell had landed during the night, before continuing their work. The injured, bleeding profusely, with varying degrees of mutilation being brought in from all parts of the North, and the surgical team working round the clock to remove bullets and shell pieces, suturing, repairing and mending, administering blood transfusions, amputating a leg in a an attempt to salvage what was possible from the human wreckage became the routine work of the Jaffna hospital.

To every man, woman and child caught in this terrible war, it was a harrowing and stressful experience. Death and destruction was all around. Somehow, people learned to adapt and come to terms with this existential fear. Some left, fleeing as refugees from place to place or to foreign shores. Homeless, helpless and dazed refugees were everywhere. Everyone realized that it was purely a matter of chance as to when one might be killed or rendered homeless. Simple activities became imbued with danger. Going to work was a daily ordeal, for no one knew whether the person who left that morning for work would return home that night or not. Fear was the rule. The tales of woe were many. Gradually, a general apathy and ennui came to replace the fear and people were numbed as a natural defense against continuous tension over too long a period.

Patients attending the psychiatric unit in the Jaffna hospital come from all parts of the North and some parts of the East. They have all been directly or indirectly affected by the war. In some it has directly precipitated illness. In others it has had a pathoplastic effect, colouring all their symptoms. Many directly affected by the stress needed only some peace and quiet, a refuge or asylum away from the stress, to recover and regain their equilibrium. Apart from those seeking help, it was apparent that everyone inhabiting the war torn areas was affected in one way or another.

The civil war, for all its smallness relative to world standards, has been a major catastrophe in the small island. It has destabilised the whole region and has not been without international repercussions. However, while a focus on the socio-political aspects would make it necessary to identify political actors in the island, the theatre of the war and violence is located right in Jaffna itself. The compact area within which the survivors and victims were located allowed us to carry out a detailed, in-depth study of the consequences of war and chronic violence on those who had no means of escape. In this chapter I shall record the events that occurred during the war years within the larger macroscopic Sinhala-Tamil-Indian relationships, and the microscopic psychological and social effects on the civilian population, from the perspective of a professional Tamil living and working in Jaffna. Or simply, it is the continuation of the narration, begun in the last chapter, of the past extended into the present, a necessary record of this momentous and turbulent period.

Post-1983

Following the ambush of the army convoy at Tinnevely on July, 23rd by Tamil militants where 13 soldiers were killed, the army went on a shooting spree. The next morning they commandeered mini buses and sped around the streets of Jaffna shooting everyone at sight, young boys going to buy bread for their families, youth on their way to tutories. Over 60 civilians were moved down by marauding soldiers in the early hours. Some of the injured were brought to Tellipallai District Hospital, where I was on duty. But there was no surgical facilities to treat them. They had to be transferred to Jaffna Hospital, but the Tamil ambulance driver refused to venture forth in that tense atmosphere. It was left to a Sinhalese driver who had brought drugs from the Ministry in Colombo to volunteer to drive and a young Muslim lieutenant who had come to the hospital with his unit agreed to give us protection by going in front with his truck. Thus, were the critically injured patients taken to Jaffna Hospital through the deserted streets.

The July 1983 ethnic holocaust was a watershed for the Tamils. It prompted many recruits to pour into the militant movements. For most Tamils the unprecedented scale or violence unleashed on them in 1983 was the final break, a clear message that they were no longer wanted in the South, that non-violent and democratic struggle was no longer viable against such aggression and terror, much of it State backed. It was a period that evoked strong emotions from the Tamils. Amidst the atmosphere of fear and insecurity, the youth came to the fore, asserting their ascendancy over the beaten (in local parlance: "sent running home from the South with their tails between their legs, like beaten dogs") and discredited elders. The spirit of revolution and defiance was in the air. Idealistic and dedicated youths pledged themselves. Many went around the villages holding meetings, educating, politicising and radicalising the people. The youth set about their task with genuine vigour to challenge the menacing State apparatus, win back Tamil self-respect and achieve the goal of independence.

Spiralling Violence

In the following period the militants launched a series of successful guerrilla attacks on the security forces. The Sri Lanka forces (being almost completely Sinhalese) retaliated by killing Tamil civilians and making large scale arbitrary arrests. Torture and 'disappearances', destruction and looting of property became rampant.

The more spectacular Tamil militant attacks included ones on the Chavakacheri Police station and the national train, Yal Devi, with hundreds of returning army personnel

aboard. It was reported that looted goods like radios, TVs, decks etc. were found strewn all around the blown up railway cars. In April, 1984, the militants blew up an army vehicle in front of the Church of Our Lady of Refuge in Jaffna town. In the army retaliation that followed, the church was heavily damaged and over 70 Tamil civilians killed.

The first killing of Sinhalese civilians in the North took place towards the end of 1984. Nine Sinhalese employees of the KKS Cement Factory were abducted while travelling by a local train and 'disappeared'. Up to this time, despite periodic anti-Tamil violence in the South starting from 1956, the Sinhalese, like the traditional bakers, carpenters etc., had felt quite safe in the North. Even after the 1983 ethnic holocaust in the South, the Sinhalese could be observed walking and talking in the streets of Jaffna. It was only in the aftermath of the '83 riots, that the State decided to evacuate all the Sinhalese civilians in Jaffna by CTB buses.

Thus, it was in 1984 that the killing of Sinhalese civilians by the Tamil militants started; it was to increase and spread to the Eastern province and the rest of the country as the war progressed.

The calculated decision to attack civilians was apparently a tactical one. The State had been increasing its repressive measures, indiscriminately arresting, torturing and killing Tamil civilians. The militants did not have the strength to take on the security forces or to protect the exposed Tamil civilian population. The guerrilla attacks on the security forces had limited success, mainly by provoking reactions and reprisals against the local Tamil population which alienated them from the State.

But the anti-Sinhalese violence was also to take a more brutal form of terrorist attacks into the heartland of Sinhalese areas itself. Here also, the aim appeared to be calculated and tactical. Such actions were also prompted by the Indian intelligence agency, RAW.

Thus, the violence of the Tamil militants differed from that of the State Forces or the Sinhalese. It was cold-blooded, calculated, carried out with precision and cool efficiency of machine guns and time bombs. Quite unlike the reactive rage of the latter which was more emotional (warm blooded) and soon dissipated itself.

There can be no 'value judgement' here about the type of violence, both being deadly and abhorrent. Perhaps one is more inhumane and sinister while the other is only humane in the sense of abattoir ethics. The importance lies in the fact that it reflects the manner in which each ethnic group defined itself as different through the 'style' of violence.

The first attack on Sinhala colonies in the North came in November, 1984. Guerrillas attacked the Sinhala settlements on the Kent and Dollar farms situated near Vavuniya on the sensitive border between traditional Tamil and Sinhala areas. The attackers came at night, took whole families out of their houses, bound them and shot them in the head, killing 70. These farms had previously belonged to a wealthy Tamil who had donated the land for the resettlement of Hill Country Tamils displaced by anti-Tamil violence in 1977. The government subsequently took over the farms, expelled the Tamils and settled armed Sinhala ex-convicts (reportedly from the infamous Welikada prison where the massacre of Tamil prisoners took place) and their families in a State sponsored rehabilitation scheme. Tamils perceived the scheme as part of the State's effort to settle Sinhalese in predominantly Tamil areas in order to counteract Tamil demands for control of these areas.

Amnesty International (1986b) reported random killings and arrests by Sri Lankan Security Forces in the surrounding area immediately after the massacre on Kent and Dollar farms. In particular, the killing of about 100 Tamil men at Iraperiyakulam army camp near Vavuniya, on December, 2, 1984, subsequent to the arrest of about the same number from the nearby villages of Chenaimadukulam and Cheddikulam.

The Civil Rights movement of Sri Lanka published an account of a reprisal killing which took place in Mannar in the North West coast of the Island on December, 4, 1984:

"An attack on a jeep which resulted in the death of one soldier and injury to several others had been followed, according to reliable reports, by a mass attack on civilians living within 3 to 4 miles of the incident, on the passengers of buses plying on this road and on the staff of the Murunkan Post Office" (they had been lined up and shot). The final death toll has been estimated at 107 (Hyndman,1985).

Another example of spiralling violence where the main victims were innocent civilians is given below :-

In retaliation to a land mine blast in Valvetithurai in which a major was killed, the army killed 70 civilians, mainly school boys, and destroyed the home of Prabakaran. A few days later, on May, 14, 1985, armed guerrillas gunned down 146 civilians, almost all Sinhalese, in the ancient Capital, Annuradhapura, a symbol of Sinhala Buddhist history and identity. The nation was shocked.

The next day there were reprisal killings of Tamils by Security Forces all over the island. A few days later the STF carried out a massacre of Tamil young men at Thambiluvil in the Eastern province. Amnesty International (1986a) summarises the reports as follows:-

"An estimated 60-63 people from the village of Maipattimunai, Thuraincelavenni and Chenaikudyiruppu had been arrested and shot by STF personnel between 16 and 18th May, 1985. Several of them were reported to have been shot dead at the time of arrest and their bodies taken away. But an estimated 40 of those arrested, mostly aged between 18 and 25 years, were reportedly taken 16 miles south to a place near the Thambiluvil cemetery ordered to dig their own graves and then shot".

Mr. Paul Nallanayagam, a retired civil servant and Canadian citizen, was arrested when he in his capacity as the chairman of the Kalmunai Citizens' committee took the complaints of the distraught parents to the local police, administrators and the press. He was detained for three and a half months under the Emergency Regulation for sedition, and spreading rumours or false statements, but was later acquitted of all charges by the High Court.

In a separate incident on the high seas off the Northern coast on 15th May, 1985, apparently as a reprisals for the Anuradhapura massacre, navy personnel killed 34 civilians including women and children travelling by the boat, Kumithini, from the Delft island. Post-mortem reports by the Professor of Forensic Medicine revealed cut injuries, including fatal penetrating puncture through the chest of an infant, using swords and knives as the cause of death. The preference for this slow, painful and bloody method, instead of the quick and direct use of the guns they had, shows the macabre sadism underlying this pathological behaviour. Many of the survivors developed severe mental illness (see Chapter 5).

A soldier went berserk and killed several civilians who had taken refuge in an army camp in Anuradhapura. A similar My Lai phenomena took place in the Killinodchi Railway station in October, 1983, when a soldier suddenly opened fire killing 14 passengers. According to Amnesty International (1986b), for the year 1985 there were 412 such extra-judicial killings of Tamils by the security forces.

Prof. Rubin (1987) of Yale University summarises these developments in the *'Cycle of Violence' as : "It is not surprising that such regulations (PTA & Emergency Regulations) together with a situation combining some of the worst aspects of both ethnic conflict and guerrilla war produced extensive violations of human rights. The press, scholars and several human rights organisations have portrayed the practices that developed in similar ways. They depict the security forces as practising indiscriminate mass arrests and detention of Tamil young men, frequent systematic torture of such detainees, and reprisal killings of Tamil civilians, covered by either denial of the arrest or reports of encounters with terrorists."*

Amnesty International reports (1985) tell of torture in army camps in the North, including Vavuniya, Palaly, Elephant Pass, Point Pedro, Gurunagar. Reports of torture have also come from a special Task Force camp at Kalladi and Kaluwanchchikudi in the Eastern province and Boossa army camp and Tangalle Prison in the South. Torture victims stated that they were stripped and beaten, with pins pushed under their fingernails and iron rods used to strike their knees, neck, face, and feet. They described being bound in chains and lowered into wells, suspended from ceilings and beaten, tormented with hot chili powder rubbed into their eyes and genitals, burned with hot rods and cigarettes, and subjected to electric shocks and mock executions. Many of these torture victims who survived developed neuropsychiatric complications like anxiety, depression, PTSD and various psychosomatic problems following their release (see Chapter 7).

Others succumbed under torture. K. Navaratnarajah, who was arrested under the PTA, died on April 10, 1983 in the Gurunagar Army camp. The post mortem by the late Professor of Forensic Medicine, Dr. Saravabhavananthan, identified 25 external and 10 internal injuries on the body. Probably as a result of this courageous report, the State granted the Forces authority (Emergency Regulation 15A) to dispose of bodies without an inquest. Arbitrary arrests of youth, particularly those between 15-35 years, became common. Detention without charges and denial of access to relations or lawyers for prolonged periods, invariably meant beatings or torture. Many detainees have "disappeared". Amnesty International (1987) describes the phenomena: "Most are eventually taken to army camps, police stations or prisons, but hundreds of others have just "disappeared." Although relatives, friends and neighbours have in many cases testified that they saw them in custody, officials to date deny any knowledge of their arrests, detention or their whereabouts. In other cases, officials initially acknowledge the arrest, informing the family that their relatives would be "released after investigation" but later denied their relative had been arrested or stated he "had been released." Amnesty has strong reasons to believe that many of the "disappeared" have been tortured, some dying as a result, and that others have been shot after arrest, their bodies being disposed of in secret." Amnesty International has 515 case histories of such disappearances.

The International Centre for Ethnic Studies, Colombo (1987), comprising a committee of leading Sinhalese citizens reported on their visit to Batticaloa :

"We encountered many mothers who walk the streets with photographs of their sons/husbands who are allegedly missing. We noted the perseverance and determination of these widows/mothers to obtain some form of conclusive evidence with regard to those who are allegedly missing. We were also witnesses to the psychological traumas of those

who have lost their kith and kin and those who were seeking the persons who were allegedly missing. Theirs was a plight which had to be seen to be believed."

As a result thousands of alienated Tamil youth were driven to arms, others left the country in tens of thousands to all parts of the world. It will not be an exaggeration to say that the Tamil militancy and the large refugee population abroad, were creations of the Sri Lanka State and Armed Forces.

The Indian Connection

By the mid 80's an estimated 562,142 Tamils, forming 25% of the entire population of the North and East (see Chapter 4) were to become refugees due to the ethnic war. About 225,000 were to leave the Island, seeking asylum in Europe, Canada, etc. But the great majority, an estimated 150,000 were to escape to India, many making the risky journey across the Palk Straits in make-shift or fibre glass motor boats. Some never made it to Indian shores, being captured by the Sri Lanka Navy patrols or drowning when the overcrowded boats capsized. The great exodus reaching South India were made to feel at home and hospitably accommodated. Assistance in many forms-food, clothing, shelter, medicine-was quickly arranged for the regular boat loads of refugees. The public sympathy and support for the 'Tamil brethren' was heartwarming. But in time the Sri Lankan Tamils were to overstay their welcome, causing, by 1987, resentment, and indifference to their plight, largely due to the unscrupulous activities of disgruntled and frustrated militant youth. With the killing of Rajiv Gandhi, the attitude and the treatment became completely negative, even antagonistic. Repatriation, with varying degrees of compulsion, of the refugees back to Sri Lanka with UNHCR assistance was begun.

On August 2, 1984, a bomb had gone off at the Meenambakam International Airport, Madras. I had just landed at Rameswaram after taking one of the last official boats from Talamannar. That there was no hue and cry across India or for that matter internationally, was an indication of the sympathy the Tamils of Sri Lanka had at that time. But as it was, many Indians dismissed it as an unfortunate mistake. The time bomb placed inside a suitcase had been intended to be loaded onto an Air Lanka plane, to explode in flight.

Two tragic events in India towards the end of 1984 had far-reaching consequences for Sri Lanka Tamils. The first was the unexpected stroke and deterioration in the health of M. G. Ramachandran (M.G.R.) chief Minister Tamil Nadu. M.G.R. was a Malayali born in Kandy, the hill country capital of Sri Lanka. He rose rapidly in the South Indian film industry to become the film idol of Tamils and Sinhalese alike.

It was the Tamil perception that MGR had deep sympathy for the Sri Lankan Tamil cause. They believed that he welcomed the Tamils who were fleeing the terrible conditions in Jaffna as well as the members of militant organisations who were to use Tamil Nadu as a place of refugee training and subsequently as the place that would serve as a launching pad for the struggle against the Sri Lankan State.

The second mortal blow to the Sri Lanka Tamils was Indira Gandhi's assassination in November 1984, by her Sikh body guards. By a strange twist of fate the Sikhs were demanding their own separate Punjabi State-Khalistan. Indira Gandhi had been keenly interested in the Sri Lanka situation, keeping herself well informed of every development and was familiar with the pertinent facts and figures, even going back to the British times. With the advice of the experienced G. Parthasarathy, she had evolved a policy of actively helping the Tamils, including the militants, while at the same time pressing Colombo to negotiate. The Research and Analysis Wing (RAW), and the Indian Intelligence, took a leading role in arming and training the militants, though officially India maintained that there were no militants or training camps (Swamy, 1994). Indira Gandhi was particularly angered by JR's pro-western policy.

Indira Gandhi's son and successor, Rajiv Gandhi's technocratic approach made him swerve away from confrontation with Sri Lanka towards 'real politik' relying on negotiations on the basis of interests and working out agreements of mutual benefit. But initially there was much confusion in Delhi's foreign policy. A bewildering succession of foreign office officials and ministers came and went, some being replaced soon after making strong pronouncements against Sri Lanka.

Thus, fate had in two successive blows deprived the Sri Lanka Tamil community of two of its strongest advocates in India. But a liberation movement or freedom struggle, once set in motion, develops a momentum and logic of its own. The inevitable historical process was to continue despite these setbacks. But India continued to treat her erstwhile pupils, the Tamil militants as 'boys', expecting them to fall in line with what she decided.

The Militants and the Public

By the June 18th 1985 Cease Fire, the militants had reached a dominant position in the Jaffna peninsula. They had come a long way from occasional guerrilla 'hit and run' attacks to controlling population and territory by restricting the army to the camps. Several attempts by the army to break out were successfully repulsed by the combined action of the militant groups such as at Sudumalai and Tellipallai.

Militarily the TELO rivalled the LTTE. PLOTE was well trained and armed but claimed to be building up for conventional military action to ensure the safety to civilians, rather than undertake guerrilla attacks which exposed civilians to reprisals. The LTTE, TELO, EPRLF and EROS formally united to present a common front, the ENLF; to meet the Sri Lanka delegation at Thimphu, Bhutan for negotiations sponsored by India. The leadership had shifted from the moderate TULF to the Tamil militants and the international recognition afforded to them by the conference was a major boost to their public image. The 'boys' had come of age and the Tamil population felt justly proud and hoped that some peaceful solution was forthcoming. Unfortunately, cracks began to appear in the militant groups.

Some prominent citizens were murdered. Citizens' Committees for each area had come up to fill the gap left behind by the self-exiled MPs and social organisations (Hoole et al, 1988). To them fell the unenviable task of collecting information on army atrocities and making representations to the army, government and Civil Rights groups. They were often called upon by distraught mothers and wives to trace, and expedite the release of those detained. Citizens' Committees were very effective in publicising and exposing some of the atrocities against the Tamils and winning redress in a few cases. They played a difficult but vital role at great risk to themselves, having to walk a dangerous tight rope between army belligerence and militant suspicion. Caught between the conflicting aims of sundry powers, several citizens committee members and social workers lost their lives.

One of the first well known citizens' committee members to suffer during the course of his duties was Paul Nallanayagam, the Kalmunai Citizens Committee chairman who was arrested, as already described, under the Emergency Regulation. The second, a leading member of the Jaffna Citizens' Committee, was Mr. C. Anandarajah, Principal of the leading Christian school, St. John's College. The LTTE claimed responsibility for his execution, the main charge being the trivial one of having organised a cricket match between Jaffna schools vs the Sri Lanka Army, in the belief that it was in the spirit of the cease fire. An old boy of St. John's College noted the hypocrisy ." about 15 months later, in the middle of war, the leaders of the LTTE would fraternise on TV screens with Sri Lanka army officers of whom Capt. Kotelawala became well known" (Hoole et al,1988). Members of Citizens' Committee doing yeoman service in a critical situation were shot. The latest in a long line of dedicated souls who lost their lives were Velmuruhan, chairman of the Kalmunai Citizens' Committee, Nadarajah of the Mallakam Citizens Committee and Fr. Chandra Fernando, Chairman of the Batticaloa Citizens Committee in June, 1988. Harassed and under pressure from all sides, many resigned their posts such as Dr.

Luther Jeyasingham, Professor Ganeshalingam and Professor Sivathamby. Prof. Sivathamby in addition to other public activities, was also a member of the short-lived committee for monitoring the 'Cessation of Hostilities'. Functioning after the 1985 Cease Fire, the committee was a good idea mooted by India, but never taken seriously by the two sides in the conflict and ended in failure.

Two other public spirited leaders to be executed, were two TULF ex-MPs who had chosen to stay behind and work with the people. V. Dharmalingam of Uduvil and M. Alalasundaram of Kopai were respected and popular in their own constituencies as well as outside. Public indignation against the killings was reflected in the angry mood at the funerals and articles in the press. Prominent administrators to be executed were Mr. Gnanchandran-Government Agent for Mullaithivu on charges of corruption; Mr. Magbul-Government Agent for Mannar for allegedly co-operating with the Indians; and several A.G.A.s in the Eastern province. Mr. Pathmanathan A.G.A. Trincomalee, was arrested under the PTA, while Mr. Antonymuthu, G.A. Batticaloa, lost his life in a land mine explosion. The G.A. for Jaffna, Panchalingam was killed by the LTTE in 1989 'for helping to organise the General Elections and running the Kachcheri for five days of the week' (Tamil Times,1988) despite their ban. The principal of a school at Tellipallai, Mr. Sivanantharajah, was shot dead by the army while attending to his duties. Grama Sevakas (Village Headman) were continually harassed by all parties and prevented from functioning. Public service had become a risky and thankless business.

Even social service workers concentrating on rehabilitation were not spared. One of the first well known cases was the killing of the Sarvodaya leader, Kathiramalai, by the EROS. Similarly Kandasamy was a dedicated worker who had given up his successful law practice to co-ordinate and organise the rehabilitation work. Having established his credentials and credibility abroad, his was the vital task of directing foreign funds from humanitarian organisations, into the right channels. He had returned to the country after the Indo-Lanka Accord to personally supervise the work, specially the TRRO. He was a meticulous and scrupulously honest man who had sacrificed much but refused to toe the line of the local militants. His motivation and loyalty were beyond question (Selbourne, 1988). His execution for being a 'destructive energy in society' was claimed by a defunct group called 'Tamil Eelam Camp' (Murosoli, 1988). The message was clear. Even those social organisations involved in rehabilitation had to work under the direction of militants, if at all.

Ordinary citizens also fell prey to these extra-judicial killings. A local writer gives an example of 'a trial by theatre': the murder of a man popularly known as 'Ranjani Kanth' by the TELO (Hoole et al, 1988). Prof. Rubin (1987) of Asia watch reports on this

phenomena: "Several of militant organisations made a practice of abducting and executing those suspected of being informers, 'anti-social elements' or 'traitors'-a term which could at times extend to anyone co-operating with political forces opposed to them. One prevalent method of execution was the 'lamp posting' in which the victim was tied to a lamp post or tree and shot, his dead body left hanging there as warning" Some of our psychiatric patients too were to end up on lamp posts (see Chapter 5).

Internal terror and totalitarian methods had taken over. Some would argue that such developments were natural in society caught in a war situation, for as Cicero says, "the law falls silent during war." But for all that, it was a striking and radical transformation in a peace loving and law abiding society. Yet the internal happenings were comparatively minor in scale and degree relative to the operations of the Sri Lanka State. For indiscriminate shooting, helicopter strafing, bombing, shelling from the land and sea, mass arrests and torture had become the order of the day. When the petrol bombs (barrels of inflammable, napalm-like substance) started to be rolled out of Avro transport planes to fall where they would, we had reached the zenith of state terrorism. These alienating activities of the State against citizens of its own country pushed the public more and more to support the militants, who thus took on the role of the defenders and saviours of the people.

The Militant Groups

What passing-bells for these who die as cattle?
Only the monstrous anger of the guns.
Only the stuttering rifles' rapid rattle Can patter out their hasty orisons.
No mockeries for them; no prayers nor bells,
Nor any voice of mourning save the choirs,-The shrill,
demented choirs of wailing shells;
And bugles calling for them from sad shires. **-Wilfred Owen**

The youth who joined the militant organisations, usually out of a sense dedication and sacrifice 'to fight for the Tamils', broke all their ties with their families (leaving unannounced in the night with a note in the sugar bottle for the mother for instance) and underwent rigorous training in armed warfare in India. The sudden traumatic breaks with the families and the taxing physical training caused many psychological casualties, particularly in young females. Those left behind, notably the mothers also, suffered from the separation.

The youth were to reach a high degree of skill in the manufacture and use of modern

weapons, specially in laying land mines and in firing locally made mortars. The once peace loving Tamil society was able to throw up, in such a short notice, able and proficient military fighters. Modern weaponry, like the AK-47 and explosives are now designed so that it does not need much physical strength or skill.

The Tamil youth made the radical transformation into an able military fighting force that received international recognition and fame. But things were not so rosy within the militant groups. A novel, 'Puthiyathor Ulakam' (A new world) published by a dissident group of the PLOTE, described how young men with high ideals and a desire to sacrifice themselves for the good of their people, were drawn into an absolute totalitarian conformism. Those who would not fall in line were tortured and brutally destroyed. Sources from these dissidents, known as the 'Spark' group, claimed that about 90 members of PLOTE had been so killed. There have also been a considerable number of authenticated internal killings within the LTTE and TELO organisations(Hoole et al, 1988).

There have been some attempts to ascribe caste affiliations to memberships in the groups and attribute subsequent conflicts to caste differences such as the age old Karaiyar-Vellala rivalry.

Whatever may be the truth of these alleged caste determinants which are such a favourite with western educated social scientists, the author's observations were that caste consciousness was minimal among the youth, in striking contrast to the marked caste considerations of the elder generation.

Following the Marxist ideology of class solidarity, the EPRLF and PLOTE have tried to forge alliances with Sinhalese leftist organisations like Vijaya Kumaratunga's United Socialist Alliance (USA) but not with the JVP, which they considered to be 'Sinhala chauvinist'. The LTTE was a well knit military hierarchy with autocratic leadership advocating a one-party system. Some have even charged the LTTE of being extreme rightist and fascist(Weaver, 1988). The LTTE has been highly suspicious of intellectualism and has relied more on emotional, gut-level instincts. Whatever intellectual elements there were in the early, idealistic stages have left the organisation. However it is precisely this unquestioning dedication and Tamil nationalism that has appealed to the common man and won his admiration and support.

Internecine Fratricide

There had been considerable personal animosity between Sri Sabaratnam and Prabakharan. Outstanding grievances and unresolved conflicts between TELO and LTTE flared up from time to time with periodic clashes and killings. In addition, LTTE suspected TELO

of being favoured by India to take over the North and East. The weakening of TELO by the exit of the Das faction and an emotionally charged situation where several leading LTTE men were lost or captured at sea by the Sri Lanka Navy, created an opportunity for the LTTE to move against the TELO in a big way, in an attempt to completely wipe out their rivals. After a week of one-sided fighting in May, 1986, the LTTE with surprising ease, emerged supreme. Probably, it was their complete determination and unquestioning obedience to the high command, coupled with an element of surprise in the use of lightning attacks that tipped the scales in favour of the LTTE. There may have been some initial confusion among the ranks of TELO about fighting fellow Tamils. The manner in which Sri Sabaratnam was killed-pumped full of bullets-was an indication of the highly volatile hatred that existed between the groups.

Many of the TELO members who were from areas outside Jaffna had to flee in fear without knowing the streets or where they were going. Many of those killed were from the East or of rural background who had joined the first group that took them. The people were so terrified that few found the courage to give shelter to the fugitives. While this unprecedented display was on, people stood mutely at junctions and watched, as persons hardly dead, were doused and burned. Hardly anyone protested, which is understandable. Some went home saying, "We have produced our own Hitlers." (Hoole et al,1988). "Now it is not merely the Sinhalese and Tamils who are divided, the communities are divided within. The poison of falsehood does not stop merely at two divisions, its divisive potential is infinite. It may be said now that every square mile of the once Gandhian Jaffna now contains at least three contrasting opinions of violent intent" (Saturday Review, 10.5.85). A physician who had watched the killings commented that the fighters looked dazed and drugged. The author was to encounter the same look, facial expression and behavioural pattern when the Indians went on the rampage in Jaffna. It is probably the outward expression of the mental state of men involved in violence and killings-a condition of frenzy or induced psychosis (see Chapter 6). The stress generated in the community by this internal conflict resulted in a noticeable increase in psychiatric morbidity and severity of psychological reactions (see Chapter 5).

In the East, particularly in the Batticaloa district, the State had been fermenting trouble from April, 1985, between Muslim and Tamil residents, by bringing in Muslims from outside, creating and arming local Muslim home guards and lending tacit STF support. Tamil-Muslim riots broke out. Animosities and rivalries were created between two communities that had largely lived harmoniously side by side. With the elimination of the TELO and later when the EPRLF-LTTE clashes broke out, the STF used the opportunity to regain lost ground and make inroads towards re-establishing control in Batticaloa.

EPRLF, like the TELO before it, suffered a fatal internal split with the military wing led by Douglas Devananda, breaking away to later help form the ENDLF. This gave the LTTE the opportunity to crush the EPRLF as it had done the TELO 6 months earlier.

The LTTE moved against the EPRLF in December 1986. Most of the EPRLF cadre in Jaffna fled without a fight. There were some obvious misgivings about fighting fellow Tamils, and a faction appeared to have decided beforehand, when a fight was in the offing, to surrender without resistance. That worked to the advantage of the LTTE and the operation was carried through without much bloodshed. The LTTE also seemed to have learnt a lesson from its previous experience with TELO and the shocked reaction of the public.

The EPRLF was much stronger in the Batticaloa district and had even come to pose an effective challenge to the Sri Lanka STF. Although there was heavy fighting with the LTTE, the EPRLF survived to continue operations in that district. Taking advantage of the weakening of the EPRLF and the LTTE, and their continuing rivalry, the Sri Lanka forces mounted a series of successful attacks in the East from the beginning of 1987. In an extensive operation using helicopter gunships and armoured vehicles, the STF surrounded Kokaddicholai and destroyed the main LTTE camp. During the course of the military action an estimated 200 civilians were massacred. Tamil men were pulled out of their houses and shot. Employees of an American seafood factory; including boys, 12 and 14 years old, were lined up and executed. A similar tragedy was to be repeated in the same place in June 1989.

The Sri Lanka forces continued to launch a series of well planned and heavily manned operations with decisive air cover in the North particularly in Killinochi and Mannar. They gradually gained control of most of the territory outside the Jaffna peninsula by early 1987. The LTTE withdrew its men under mounting pressure and concentrated them in Jaffna. The Sri Lanka forces were now poised for a final offensive to recapture the Tiger stronghold-the Jaffna peninsula itself.

LTTE Rule

Jaffna functioned as a 'semi-liberated' territory under Tiger control. Foreign journalists, Sinhalese leftists and others flocked to see the new system. The public got a foretaste of how things would be under the LTTE one-party rule. To many it was a time of hope and exhilaration ending in disillusionment and despair.

People were able to take up the strands of daily life once again, except for the unpredictable

shelling from the camps and occasional bombing raids and helicopter strafing. The LTTE tried its hand at social welfare projects, initiating primary health units, running co-op hospitals, opening reading rooms, libraries and children's playgrounds. Cultural activities were organised. They introduced a tax system and made mutually beneficial arrangements with merchants and businessmen. The transport and sale of petroleum products had become a lucrative business during the war (a bottle of petrol selling as high as Rs.100, later as high as Rs. 1000 or more).

Rural courts under the LTTE functioned creditably, compared to the bureaucratic delays and costs of the official courts. It is interesting that the official judicial system in Jaffna which was effectively reduced to holding only inquests, signaled its own defiance and independence of the State. Some enterprising judges returned a verdict of homicide on deaths caused by shelling or helicopter firing ordering the arrests of the 'murderers', despite the fact that an official circular denied them the right to rule on such cases. A crusade was launched against trafficking in Kasippu (illicitly brewed liquor), narcotics and ganja. LTTE put up a daily news bulletin at all junctions and requested feedback suggestions from the public through the 'yellow mail boxes'. Much of their propaganda work was carried through their television network (Nidershanam), the local press which they controlled, posters, village level organisations, meetings and 'loud-speaker vehicles.' The LTTE quietly infiltrated almost all the organisations, administrative bodies, public committees, hospitals, schools, etc. They claimed that there was a 'Tiger supporter' in every home.

In our desire and effort to
establish a life of worth for
humanity
we encounter so many
impediments!
Cruel eyes oversee our paths,
and a bitterness bruises our
hearts, in a kindling.
The life of a cadaver, lived in a
senseless forgetting
of human feeling, is not the life I want,
living in this world. **-Selvi**

Thiagarajah Selvanithy (Tamil: nry;tepjp jpahfuhrh), also known as Selvi, was the 1991. PEN award winning poetess executed by LTTE. (https://polity.lk/selvi-loss-dissent-and-hope-sivamohan-sumathy/)

But behind the scenes, political killings characteristic of totalitarian regimes went on, ignored and unnoticed. Any opposition or challenge to power was put down ruthlessly and quickly. The LTTE's control and power was so overwhelming, with its legitimacy enhanced by the violence of the State, that aggrieved parties found it impossible to find redress for injustices. But two killings brought out public protests even under these oppressive conditions. One was at Pasaiyoor, when the whole village rose up in defiance after the killing of Edward. The other was the Vijitharan affair at the University of Jaffna. The LTTE temporarily bowed under public pressure.

While Jaffna was under the effective control of the Tigers, the government of Sri Lanka continued to pay salaries, pensions and other benefits from Colombo. Electricity, drugs, and other essentials were still provided. Even flour, sugar, infants' foods and other food items found their way into the peninsula. A lot of credit must go to the conscientious Sinhalese administrators who inconspicuously kept the war ravaged areas supplied. Some would argue that the State had its own ulterior motives for keeping a semblance of control over these areas, if for nothing else, at least for propaganda purposes. They could not very well admit that they had lost control over these territories which would be almost tantamount to seceding it to the Tigers. Further it would force India to take up supplies to the besieged areas.

When the Tigers officially announced that they would take over the administration in stages from 1st Jan. 1987 starting with a tax on vehicles and control of road traffic, the Sri Lanka Government pre-empted their move by enforcing a fuel embargo. The embargo in turn evolved into an almost complete blockade of all essential items due to delays and hold ups in checking at the army camps. Fresh food items rotted in the lorries. The farmers were the most affected from the fuel shortage.

As a whole, Tiger rule benefited the common man, giving him a sense of dignity and a degree of security after a long time, though existing in a war situation. This drew a good number of Tiger supporters and ardent followers. Apart from the opportunists currying favour with those in power, there were the genuine fans with a good sprinkling of the older generation who took on the role of spectators enjoying the exploits of the Tigers. There grew an enthusiastic band of supporters called 'rasikar' (those who appreciate) much like Hemingway's 'Aficionados'. People identified themselves with their brave boys who were their own younger selves going into battle and emerging victorious. The youth provided a means for the resurgence of flagging spirits and emotional exultation.

The deaths and funerals of LTTE cadre became public events where considerable emotion was generated. Deaths were announced through loud speakers in vehicles circulating

through the villages at night. Funeral decorations with cut trees and photographs of the fallen warriors were displayed at junctions while sombre funeral music was broadcast throughout the day. One or more days of mourning were observed as officially enforced hartals. The local TV, press and other media honoured the dead. The whole atmosphere was charged with a heroic, solemn mood. The death of the Mannar commander Victor on the battlefield at Adampan brought forth spontaneous grief. His body was taken in state around the Peninsula. Similarly, the death of many of the LTTE leaders like Radha, Kugan, Thileepan and others evoked considerable popular sympathy and emotion and their funerals took on the form of a public ritual. In several cases there also remained silent skepticism about the declared cause of death or misfortune.

The Tigers

The Tigers were a closely knit, disciplined organisation that quickly won the respect and fear of their opponents. In fact all the Tamil militants and even the ordinary Tamil man was called by the blanket term 'Kotiya' (Tiger) by the Sinhalese. They proved themselves a cohesive military unit that showed rare courage, determination and skill on the battlefield, winning them international fame.

The LTTE was a rigidly controlled autocratic organization where its members swore a personal oath of allegiance to their leader, Prabhakaran, every morning. At the end of their training they are make to wear a cyanide capsule around their necks so that they can commit suicide if captured. Indeed the cyanide capsule is a symbol of deep meaning to the Tigers and public, signifying complete dedication and absolute sacrifice. It gives the wearer a rare determination and undaunted courage. As much as on third of LTTE deaths may have been by this method of 'altruistic suicide' (see Chapter 5).

The LTTE showed extreme puritanism in matters of alcohol, drugs, sex, corruption and other human weaknesses. Part of the problem was that the LTTE did not trust any one, being highly suspicious of everyone and everything. It appears that they shared the paranoid personality so common in the Tamil man. The actions of the LTTE become more clear if we see the world from their perspective.

A Jaffna University don has this say of the LTTE: "In mitigation however, the LTTE is the product of a brutal world; a world where great leaders, men whose education and maturity entitles them to know far better, routinely use deceit and mass murder as legitimate forms of action.. This can be seen in the American use of contra rebels in Nicaragua and in the Soviet meddling and shifting of sides in Eritrea. That President

Reagan delegates authority to decide on murder and assassination to distant CIA officials or proxies does not make him less of murderer than a bandit who makes his own decisions. The same can be said of most big nations which observe little restraint in the way of law or principles when dealing with foreigners, especially by proxy. The RAW cannot claim moral superiority over the Tamil militants. The fight against terrorism will be futile as long as the world's leaders play with terror when it suits them. The impressionable young minds of the LTTE were moulded by the cynicism and duplicity they encountered in their dealings with the TULF, the Tamil elite, Sri Lankan and Indian authorities" (Hoole et al, 1988).

Trincomalee

Trincomalee had been a seething hot bed of ethnic strife from 1983. The violence against the Tamils became quite serious in June, 1983. Piyadasa (1984) writes "Until the violence began, Trincomalee was a town in which there was a fair proportion each of Sri Lanka Tamils, Moors and Sinhalese-with the Sri Lanka Tamils as the largest community. Almost a hundred years ago, at the time of the 1891 census, 9,536 (79%) of the town's population of 11,948 had been Tamils. It had grown considerably by 1946 under the stimulus of being the major British naval base of South Asia. Communalist Governments had tried to settle Sinhalese in (and around) the town. It would require a massive campaign of terror against workers, traders and other residents, and considerable killings, to change the population radically and make Trincomalee a predominantly Sinhala-Buddhist town. The UNP leaders who started on this cruel and barbaric operation must have known what it would cost."

In many ways Trincomalee represents in microcosm the whole ethnic problem of Sri Lanka. The three communities Sinhalese, Tamils and Muslims are mixed by now in an almost equal proportion but their relationships are not on an equal footing. The greatest tragedy is faced by those residents who have intermarried and there are many of them who have defied the ethnic hatred that has effectively divided the rest of the country.

Tamils are the oldest group tracing their origins to the Chola nobles; they associate their culture with the historic Koneswaran Temple. Sinhalese settlements may have existed around the ancient Buddhist Vihares found at Triyai in Trincomalee. The Muslims are probably descendants of traders who migrated from Arabia and the South Indian coast before the Portuguese era. The development of Trincomalee as a major port by the European imperial powers, particularly the British Navy, increased the influx of all

communities, predominantly the Sinhalese but also Tamils, Burghers and even Chinese. From the time of D.S. Senanayake's colonisation schemes, the Sinhalese have been settled in the Trincomalee district, and administrative districts like Seruwavilla have been carved out for them. Sinhalese settlements have been created up along the coast, around the town, within the market area, and at major junctions leading out of the city (such as Sirimapura, Abheyapura, Mahindapura, Pattispura).

All these settlements were established with State funds-houses built, facilities provided and monthly incentives paid.The Mahaveli Development Project and various corporations -such as those in timber, sugar, mineral sands, cashew, and fisheries, including industries with foreign multinational (notably Japanese) collaboration such as Prima Flour and Cement-had built quarters and other facilities for their predominantly Sinhalese employees. From 1983 there had been a systematic destruction of Tamil villages-52 in all-and all the Tamils living outside the city became refugees. The village of Uppuveli, where the author lived for a time, was three miles north of Trincomalee. It had once had 300 families, 75% Tamil, and the rest Muslim. But from July 1983 to January 1986, Uppuveli had been systematically devastated. When travelling in Trincomalee in 1984 when the author was working there as the MOH, such sights were common. The jungles and elephants took over.

In July 1983 there were many Tamil killings. During curfew hours hoodlums and Home Guards attacked them at home and if they tried to flee, the army, navy or police would shoot them as curfew breakers. The Navy was particularly harsh in 1983 during curfew hours, burning houses systematically till dawn, when they returned to camp.

In retaliation Tamil militants also increasingly attacked Sinhalese civilians in Trincomalee. In April 1987, 126 Sinhalese, mostly army personnel and their families, were killed at Kituluttawa when they were returning by bus after celebrating the New Year. Attacks on Sinhalese villages become common since the arrival of the Indians. More than 200 men, women and children have been killed. Many have become refugees. After the signing of the Indo-Lanka Accord the Sri Lanka Forces were confined to barracks till April 1988 and during that period the Tamil militants got the upper hand, sometimes it is alleged, with Indian complicity (Rubin, 1987). In Sept. and October, 1987 armed Tamil youth were seen driving out Sinhalese from their villages. As of March 1988 the LTTE has also stepped up attacks on Sinhalese, killing over 100. There appears to be a rush by the Sinhalese and the Tamil leadership to resettle the villages that have been vacated but the refugees did not show much enthusiasm.

Tamil-Muslim relations which had over the years been peaceful, have also flared up. Mary Weaver (1988) quotes a Muslim magistrate in Trincomalee: "…the Government most certainly recruited Muslims into the Home Guard in order to split the Tamils and the Muslims …any Government would like to snatch us, so would the boys. It's like a game of rugby and we are the ball...For God's sake let us live in peace ! We are thirsting for it, like a vast desert thirsting for rain."

Trincomalee is in many ways the key to the solution. The Tamil leadership envisions it as their capital and a vital link in the merger of North and East. The natural harbour is to be the base for development in trade and commerce. The Sinhalese are in no mood to give up the Trincomalee harbour, let alone accepting the North-East merger. Many foreign eyes have also coveted Trincomalee. It had been rumoured that the United States wanted Trincomalee as a base for the Seventh Fleet. India perceives the natural harbour as strategically vital for the defense of the Bay of Bengal and the Indian Ocean.

Weaver (1988) quotes Colonel Suriabhandari, Indian Armed Forces Commander then in Trincomalee. "It is extraordinary. It's depth is limitless, it can camouflage a hundred to two hundred ships. It is breathtaking. And everyone wants it".

The PLOT Thickens

Two bombs ascribed to the Tamil militants went off in Colombo. On May 3, 1986 a bomb exploded in an Air Lanka Tristar jet aircraft at Katunayake International airport killing 16 people and wounding over 100 others, including foreign tourists. Fourteen people were killed in a second bomb explosion at the Central Telegraph Office in the heart of Colombo. The usual backlash of violence against the Tamils in the South did not occur, but the State itself undertook massive reprisals in the form of bombing and shelling of Tamil areas in the North. As following the Trincomalee massacre and the Pettah car bomb explosion the next year, the retaliation by the State was by then automatic and much more intense.

Meanwhile, from 1986 Prime Minister Rajiv Gandhi and President Jayawardene had been meeting and exchanging views through emissaries, 'notes' and telephone calls in a bid to find a solution. The failure of the Thimphu summits and other efforts at mediation made Rajiv adopt a more direct and personal role in the negotiations. Much of the ground work was laid by Rajiv's Union minister Chidamparam from the centre, State minister P. Ramachandran from Tamil Nadu, and Indian representative J. N. Dixit in

Colombo. The summits at Delhi and at Bangalore after the SAARC conference promised much but floundered because of unbridgeable gaps.

Prabhakaran had by now been de facto recognised as the sole representative of the Sri Lanka Tamils. Preliminary to the Bangalore summit in October, 1986, Prabhakaran among other Sri Lankan Tamils, had been taken into custody, ostensibly as a precautionary measure, Mohanandas a police higher-up with dubious connections, playing a prominent role in these strong arm tactics. Apparently Prabhakaran had been treated shabbily. Subsequently the LTTE's communication equipment and arms were confiscated. Prabhakaran responded with a death fast without even water. With mounting reaction in Tamil Nadu, India returned the equipment. Thus, it is quite evident that India was trying to pressurise Prabhakaran into accepting what was called the 'December 19 Proposals'. From the Madras prison, he was escorted to Bangalore by special plane to take part in the negotiations. Though offered the chief ministership of the Northern province and a proposed division of the East into Tamil, Muslim and Sinhalese areas, he remained adamant. He returned to Jaffna in Jan. 1987 vowing never to return to Indian soil unless he was treated with due recognition and respect.

Sri Lanka responded with an all out effort at a military solution, culminating in 'Operation Liberation' to recapture Jaffna. By now, the Sri Lanka forces, with the aid of a soaring Defense expenditure and foreign help and advice, had been beefed up with well trained men-STF trained by British SAS commandos, Black Shirts by Pakistan, equipment (T-56 machine guns from China, Bell helicopters from USA, buffalo armoured cars from South Africa, Italian bomber planes leased from Pakistan etc.) and had evolved a dependable, modern intelligence system (with Israeli help) capable of planning and carrying out well co-ordinated attacks. They successfully re-asserted themselves throughout the North and East, notably in Mannar and Kilinochi before turning their attention on Jaffna. The militants retaliated by carrying out large scale massacres of Sinhalese civilians.

Bombing and Shelling

From March 1987 the Jaffna peninsula came under a barrage of bombing and shelling. The bombings including rockets or air-to-surface missiles fired from helicopters and planes had been going on intermittently from 1986. People had initially reacted adversely to the bombing and several patients suffered an acute psychotic breakdown after the first bombing attack (see Chapter 5). Soon the public adapted to the bombing. Almost every house boasted an air raid shelter with varying degrees of facilities.

By 1987, the heavy artillery guns that had been painstakingly brought in by slow moving convoys, could shell all points of the peninsula from the many army camps. In addition, the modern Naval boats could chip in with off-shore shelling. The unpredictable shelling was perhaps the most frightening aspect of the whole war and caused the most amount of stress and psychological breakdown (see Chapter 5).

The bombs and shells had no obvious military purpose as they were notoriously inaccurate and always seemed to miss their intended targets. It definitely had a psychological terrorising effect on the general population. That this may have been the intention became clear when the infamous barrel bombs of napalm-like inflammable material began to be rolled out of the Avro transport planes to land where they would. The use of these modern weapons of destruction to terrorise and kill its own citizens cannot be justified by any means and warrants the indictment of the state for war crimes.

Struggle for Jaffna

When the government ordered the Jaffna hospital, the only provincial hospital serving the whole North, to be closed down, it was a sure indication that a big offensive was being planned. There had been adverse publicity about shells falling on the hospital. The hospital stood in the centre of the Jaffna Town and the forces wanted a free hand when they made a bid for the town while the LTTE strongly wanted the hospital and the civilians in the town to remain as a deterrent. The order to close the hospital was later retracted under public pressure, the GMOA playing no small part.

Phase 1 of Operation Liberation got under way on 26th May 1987. The army then moved out simultaneously from all the camps in the peninsula, the real push being confined to the Vadamarachi area. Men were heli-dropped at critical junctions. It was a well-planned, strategic, and efficiently executed operation. A crucial difference from previous attempts was that the Sri Lanka army maintained a steady disciplined advance under heavy fire, despite the casualties and despite the land mine explosions. A second factor that is reported to have caused confusion among the LTTE ranks was the presence of Prabhakaran. Apparently Sri Lanka intelligence had got wind of his movements and timed the 'Operation Liberation' to coincide with his stay in Vadamarachi and planned to capture their quarry by closing all exits. The LTTE expended a lot of energy and resources in getting their leader out of the closing trap to safety. The LTTE made a quick withdrawal and Vadamarachi fell into Sri Lanka hands by June 1 and almost the whole Vadamarachi population became refugees.

People were told by radio to take refuge in temples and schools. Subsequently three such refugee camps were shelled with many civilian deaths. There was widespread looting by troops. Soon, however, the Sri Lanka Government launched a well-publicised public relations campaign to win back those who were left.

Initiative and momentum continued to be on the side of the determined Sri Lanka army as they advanced in a wide sweep towards Tellipallai before proceeding to Jaffna. The LTTE was in disarray, low in arms and morale. Scuttle plans were already being put into effect. The BBC's Mark Tully reported that Jaffna would fall within the next 48 hours. There was general panic in Jaffna. At this point on June 3rd, India intervened with a convoy of fishing vessels loaded with relief supplies. The convoy was stopped at the maritime boundary of Sri Lanka by a lieutenant in the Sri Lanka navy who is reported to have told the Indians to take back the supplies and distribute it to the starving millions in India. The next day the Indian air force transport jets escorted by MIG fighting planes para-dropped 25 tones of relief supplies in Jaffna, issuing a direct warning or 'demarche' to Sri Lanka and the final stage of Operation Liberation was halted. There was great jubilation in Jaffna. A thankful mother called the 'mercy mission' a gift from God (Saturday Review 20.6.87).

The initiative was now with India and it pressed for a 'presence' in Jaffna, ostensibly on humanitarian grounds, to distribute relief supplies. It was agreed (under strong 'diplomatic' pressure) to carry this out jointly with Indian and Sri Lanka Red Cross personnel. On the 25th of June, the Indian ship, Srivastava, bringing relief supplies docked in KKS. Massive crowds welcomed the Indian Embassy officials, Mr. Puri and Capt. Gupta, together with the Indian Red Cross officials along their route to Jaffna. In scenes reminiscent of the entry of the allies into Paris at the end of World War II, there was garlanding and spontaneous expression of relief and joy. Some broke down in front of the Indian officials and cried "India save us".

The LTTE attempted to maintain its dominant position in the minds of the people while stiffly welcoming Indian help. From the start they tried to keep a tight rein on the public's expression of emotion and support towards India. The paranoid minds of the Tamil men about the intentions of India were activated by propaganda pamphlets, and stories of rape by the Indian army in Bangladesh were circulated. It is noteworthy that many of these paranoid fears were later fulfilled.

Indo-Lanka Peace Accord

The Indo-Lanka Peace Accord was acclaimed all over, both locally and internationally, an indication of the good will and influence India enjoyed. The militants in Sri Lanka both Northern and Southern, expressed their reservations and opposition in varying degrees.

J.R. was to later confess that if Sri Lanka had continued on its old course, it would have eventually resulted in the establishment of a separate Tamil Eelam. He must have realized apart from the spectre of an Indian invasion, that even though they could take Jaffna with heavy casualties, both military and civilian, it would be extremely costly to hold on. The Tigers would merely withdraw and continue fighting a guerrilla war. They may win the battle but the war will go on. This would mean a continuous loss of life but more critical to the government was the economic cost.

The Indo-Lanka Accord was signed in Colombo on July 29, 1987, despite violent opposition in the South. The most violent opposition came from the proscribed, Sinhala nationalist Janata Vimukthi Peramuna (JVP) which launched a campaign of assassination against supporters of the Accord, including those contesting the provincial council elections. The sensational grenade attack on government MP's inside the Parliamentary building in Jayawardenapura, left 2 dead including a minister and injured several others. The minister for National Security was severely injured, but the President miraculously escaped unscathed. Since then, the JVP and its military wing (DJV) accelerated their activities. There had been a rash of assassinations of police officers, UNP party members and other politically active groups (notably the United Socialist Alliance-USA) as well as death threats, arson and sabotage. Armed youth also engaged in robbery and have attacked police and military posts. The raids on the Katunayake air port, Kotalawala Defense Academy and some heavily guarded army camps showed the increasing military prowess of the Southern militants as well as the active support they had from within the ranks of the security forces.

The government responded with a massive militarization of the South with large scale security operations involving the police, STF and the army who were made available by the arrival of the IPKF in the North and East. A new elite unofficial unit surreptitiously called the Green Tigers was alleged to be operating as an extra-judicial arm of the State. The government also announced and put into operation, plans to recruit and train up to 30,000 men as militia or Home Guards to carry out various functions. The whole nation was turned into a security-conscious militarized State with a bewildering array of arms, uniformed men, barriers, checks, searches and ID cards, creating an atmosphere of tension and insecurity.

Following the Accord, the East became a hot bed of trouble as each side attempted to establish its supremacy in the area. The Sri Lankan authorities rushed in Sinhalese colonists, many of whom had been displaced as refugees by Tamil militant activity.

In addition to the internecine war between Tamil militant groups, Tamil-Muslim animosities leading to violent clashes, erupted in the East. There were serious allegations of Indian indifference or connivance with some militant groups against the Muslims. A Muslim commander was appointed to the Eastern IPKF to allay Muslim fears.

Towards Confrontation

Before the signing of the Accord, Prabakharan was dramatically air lifted to Delhi on July 24, 1987 in an attempt to persuade him to also become a signatory. When Prabhakaran was taken from Jaffna by Indian air force helicopter, the local press hailed it as an official recognition and honour for the besieged Tamil nation. Apparently Prabakharan was kept 'incommunicado' while considerable pressure was brought on him to agree; even a considerable financial remuneration was offered. But a hurried Rajiv Gandhi had to leave for Colombo without Prabhakaran's consent. He is reported to have held out for a permanent merger of the North and East together with a more detailed and concrete devolution package. Public protests in the form of sit-ins and road blocks to the Indian troops in Jaffna compelled India to return the intransigent Tiger leader to where they had taken him from.

The exiled militant groups who had been cooling their heels in Tamil Nadu also made their appearance under Indian protection. The LTTE strongly resisted the political re-entry of the other groups. Old rivalries, grievances and a burning desire for vengeance sparked off a series of confrontations and abductions, inevitably ending in internecine killings once again. The first reported murders were those of 3 LTTE men, allegedly by PLOTE, in the Mannar district. The LTTE claimed that they had asked the IPKF for protection but had been ignored. By the latter half of August, killings and counter-killings among the militants were reported from Vavuniya, Killinochi, Mannar and Trincomalee.

Then in September, Professor Rubin (1987) reported in Asia Watch, "In several co-ordinated attacks on Sunday, September 13, LTTE gunmen in Batticaloa killed at least 75 members of PLOTE and EPRLF (some observers put the dead at over 100). Many of the dead had apparently just been released from Sri Lanka prisons. About 20 PLOTE members were ambushed at the beach after going for a Sunday swim". Joseph Kingsley Swamipillai, Roman Catholic Bishop of Batticaloa, stated of these attacks, "It is a very sad thing. There had been no fighting. All the dead were ambushed and eliminated."

Over 100 members of PLOTE and EPRLF sought protection of the police and sheltered in STF camps. Indian Peace Keeping Forces were deployed in Batticaloa but were unable to halt the killing for several days" (Rubin, 1987).

The LTTE saw themselves caught in a 'do now or die later situation'. They feared that their organization, which in their view, had sacrificed the most, fought the hardest and obtained most of the concessions for the Tamils, would be eclipsed and politically annihilated by the others.

The Tiger-Indian Impasse

The Tigers, being wary of politics, refused the Indian gambit and rather chose, or rather were forced by its own mental make up, to oppose her by force. The writing was already on the wall when the Indians landed in Jaffna.

A certain degree of fear and suspicion of India was created in the people's mind by LTTE propaganda. India no doubt bent over backwards in trying to win over the Tigers. Their vehicles flew the Tiger flag and they treated the Tiger leadership with due respect and honour, carrying them around in helicopters. There was considerable fraternising, notably in the marriage ceremonies of Tiger leader, Kumarrapa. India inadvisably chose always to deal exclusively with the LTTE, recognising it as the sole representative of the people, thus effectively marginalising the public (Hoole et al, 1988)

The Tigers for their part only made a token surrender of arms (reportedly those captured from other groups) while holding on to their trusted weapons. They launched a series of political moves, using the public, to mount pressure on the Indians. Professor Rubin (1987)describes the situation, "At the end of September emotions were at a high pitch in the Northern and Eastern provinces. On September 26, less than two weeks after he began a fast (without water) onto death to protest the way the Accord was being implemented, Jaffna LTTE political leader Thileepan died before a crowd of thousands in Jaffna".

Following Thileepan's death, public emotion had been worked up to a fever pitch. The mass funeral of the 13 dead Tigers who had committed suicide in army custody stirred up emotions even further. Angry, chanting crowds had marched into Indian army camps to hand over petitions. On October, 9, Indian Defense Minister, K. P. Pant, and President Jayawardene ,in a joint press conference, declared, in effect, war on the LTTE. On October, 10, the LTTE attacked an Indian para military, Central Reserve Police Force (CRPF) patrol jeep at Tellipallai junction, killing four. The war for Jaffna had begun.

Operation Pawan

A good description from the Indian side of the military Operation called 'Pawan' (wind) is given by Shekhar Gupta (1988) and Swamy (1994). A more detailed account of what happened in Jaffna from village to village can be found in The Broken Palmyra (Hoole et al, 1988), and forms the background for chapter 6 of this work. In these accounts, we have two strikingly different perceptions of the same event, one from the Indian army and the other from ordinary civilians, as discussed in Chapter 3.

As the Indian Army's Chief of Staff, General Krishnaswamy Sundarji, ironically a Tamil, was to later admit "Operation Pawan" was not just a military operation but a "politico-military operation." And "estimates of morale and staying power of the militants were not accurate enough". Air Commodore Jasjit Singh had expressed the view that "there would have been less foul-ups and it would have been a better operation had there been more time. But one doesn't really know what compulsions and imperatives Sundarji was working under". By all reports Operation Pawan was launched hastily under political pressure without adequate intelligence, with overconfidence and a clear underestimation of the motivation and resolve of the enemy (Tigers) (India Today, 1988). As Gupta (1988) put it, " No one has learn more from Jaffna than us. This was our first real lesson in FIBUA (Fighting in Built-up Areas)!"

Thus, what turned out to be the longest war for the fourth largest army in the world with famed martial units like the Sikhs, Gurkhas, Rajputs, was a bitterly fought, costly affair. They had grossly underestimated the Tiger's fighting power and lost heavily "over 7 percent of the men who fought (higher than in Pakistan) and officers (ratio of officers to the men of other ranks killed in Sri Lanka was an all time high for the Indian army)" (Gupta, 1988).

It took the Indian army something under 3 months to subdue the Jaffna peninsula. They first withdrew their troops which had been moving around freely in the Jaffna peninsula to the main base camps in Palaly, Pt. Pedro, KKS and Jaffna Fort. The Indians launched a conventional five-axis thrust under separate Brigades towards Jaffna.

As the saying goes 'all is fair in love and war' and under the complete war situation no quarter was given. Prof. Rubin (1987) concludes, "Clearly both the IPKF and LTTE did not care how many civilians lost their lives during the conflict."

For the Tigers it was a desperate situation; Jaffna was their last stronghold and base, vital for political, military and propaganda purposes. They used everything they had against the Indians and undoubtedly proved their military capability against one of the best

armies of the world. But they, perhaps in a hopeless situation, fought from behind civilian cover, from hospitals, temples, schools and refugee camps. They used women and children for military tasks, and it is claimed, mutilated the bodies of dead jawans. Their unconventional guerrilla tactics completely unnerved the Indian army. For India it became a prestige issue after the initial reversals to take Jaffna at all costs. Thus, as 'Delhi pressed for results, more troops were flung into the furnace' (Gupta,1988). For many jawans this was their first experience of war, particularly a guerrilla war, in a foreign land, unprepared and inadequately supplied for what happened. There can be no doubt that the whole exercise was a valuable field experience for the Indian army. Specially the Sikh and Gurkha lower ranks would have learnt lessons of guerrilla warfare, from masters in the science that may have, once they are discharged, repercussions detrimental to India as a whole.

An Exercise in Indian Power Projection

From the beginning of 1988, the situation gradually returned to 'normalcy' during which hostilities were slowly reduced. It is to the credit of the Indians that during this 'third phase' of their operation in Jaffna, they tried to ensure the physical security and safety of the Tamil community. Large scale killings, shelling and bombing ceased. The internal noise pollution from the continuous firing and shelling that had reverberated throughout Jaffna from the beginning of the war thankfully fell silent. People once again were able to pick up the threads of their lives, return to their homes, engage in their normal occupations like agriculture and fishing and earn their livelihood. India started repatriating Lanka Tamil refugees from Tamil Nadu, resettling them in their old lands, with necessary aid. Yet the political problems remained unsolved. Jaffna continued to be an occupied land under martial law with Indian jawans on duty in every nook and corner of the land. A general night time curfew and sudden day time local curfews, searches, arrests, detention, torture, deaths, and 'disappearances' continued as daily occurrences in the land. The coming of the Indians also meant a cholera epidemic and a rinderpest ('komari') epidemic among goats (the Indians brought their own herds of goats with them for food).

The Indian offensive against the Tigers continued albeit in fits and starts. The famed hunters of the Bengal Tiger were obviously at pains to bring the Tamil Tiger to bay. Large scale operations in Mullaithivu, Batticaloa and Vavuniya achieved limited success. The IPKF is reported to have been much better behaved, acting with restraint and politeness to civilians during these military exercises. Apparently they had learnt a lesson

from their Jaffna experience. As their operation called "Checkmate" indicates, their policy had been a slow game of neutralizing and cornering the LTTE, forcing them to negotiate and come out in the open, to join the political process. To a large extent the LTTE arms had been recovered, their movements hampered and a good number killed or captured. Though militarily weakened, the LTTE continued to be politically active. Political killings, particularly of those co-operating with the Indians or rival militant groups, and guerrilla attacks on the Indian army continued. Large scale Sinhala civilian massacres, allegedly in response to their increasing resettlement in the North-East, including the strategic (dividing the North and East) Manal Aru scheme in Mulaithivu, were reported. Civil disobedience like hartals, civil administrative disturbances like the non-functioning of Kachcheries, banks, etc. were remarkably successful (more out of intimidation than anything else). The whole time, even during the actual war, negotiations between the various parties in conflict had been going on and various agreements and 'understandings' emerged from time to time, depending on changing perceptions of interests. Though there were claims of representing the 'will' or aspirations of the people, ordinary citizens were nevertheless kept in the dark about the twists and turns of political manoeuvring and appeared to have always ended up suffering the most from this cynical game of power.

Perhaps the most tragic event for Sri Lanka as a whole in 1988, was the killing of SLMP leader Vijaya Kumaranatunga by the JVP. If anyone could have taken Sri Lanka out of its present mess, it was Vijaya. He had won the respect and faith of both Sinhalese and Tamils by speaking out from a principled position in an ideologically charged atmosphere.

It further raises the question whether such genuine personalities will be allowed to survive within the present system. This tragedy brings out the bankruptcy and utter waste of violence. It is so easy to destroy. A bullet, a bomb, and a life's work painfully built and a promising career are suddenly ended to the detriment of society. Vijay could have in time achieved non-violently and with less waste, what violent extremists are fighting for, but will never achieve. For violence means destruction, death, animosity, hatred and conflicts and the ideal dreamed of is ultimately destroyed in the very process of violence. We need no better example of the continued failure of violence than the Tamil separatist and militant response in the face of State violence and repression, in time building up to a civil war for separation. Certainly, a group may be able to capture power and even stay in power, however precarious, by resorting to the gun barrel, but by then there is no longer the question of the welfare of the nation, or the common man. It becomes a question of personal power.

Similarly the brutal murder of Rajini Thiranagama in the North on Sept. 21, 1989, epitomised the situation among Tamils. An intellectual who was the only lecturer in Anatomy at the University of Jaffna Medical Faculty, Rajini was at the same time a deeply concerned human being working tirelessly for the very survival of the community. She had courageously chosen to work at the grass roots, helping those affected, particularly women and young students, highlighting their problems and exposing human rights abuses, painfully building a society that would determine its own future with dignity. But in their struggle for power and control, the Tamil militants, here the LTTE, wanted a spiritless and submissive society terrorised to obedience, and thus killed off one of the most valuable resources the Tamil community had.

Factions fighting each other, internecine killings, political murders, bombs and a persistent atmosphere of terror have become the order of the day. A bewildering array of political groups are at each other's throat. Issues have gone out of focus and lost importance. The Tamils are divided into LTTE, PLOTE, EROS, EPRLF, TELO, EPDA, Tamil National Army and more recently EPDP. The Sinhalese have the Sri Lanka Army, Navy, Air Force, Police, STF, Green Tigers, JVP, DJV, Red Army, Black Cats, Home Guards, gun wielding politicos and security guards, while the Indians have fielded the IPKF and RAW, and the Muslims have belatedly produced their own El Jihad etc. All these various groups are absolutely convinced that their narrow interests are of paramount importance and they have the panacea for the ills of their community. They all use the most modern techniques of violence to achieve their partisan ends.

There were increasing reports of massive arbitrary arrests, detention of thousands of suspects, torture and disappearances in the South under the infamous PTA, Emergency Regulations and the Indemnity Act. By another ironic twist of fate, the pattern of repression of the North and East repeated itself in the South.

The JVP drew its support from the deep South, appealing to anti-Indian Sinhala nationalism and challenging the legitimacy of the government. A reported 30,000-60,000 people died in the ensuing struggle for power. The JVP organised hartals and work stoppages, carried out sabotage, issued threats and killed political opponents, creating a situation that virtually paralysed the country and brought the government to its knees. Various attempts were made to negotiate with the JVP, including offers of cabinet posts, of lifting the proscriptions, of letting the Emergency Regulations lapse and thus releasing political detainees, of setting a date for General Elections, of announcing intentions to replace the Indo-Lanka accord with a Friendship Treaty and of the phased withdrawal of Indian troops, all to no avail. For its part, the government re-introduced laws allowing

the disposal of bodies without inquest as several paramilitary 'vigilante' groups like the Green Tigers, Red Army and Black Cats carried out counter killings against the JVP. Derek Brown of the Manchester Guardian reports (15/12/88): "The JVP's ruthlessness in killing government employees has been matched in recent weeks by a vicious bout of counter-terrorism by the security forces and gangs of hoodlums attached to the ruling party. There are daily reports of disappearances and casual murders and of men being dragged from their families in the dead of night to be tortured and killed and their bodies destroyed on makeshift pyres of old tyres".

EPRLF & ENDLF with tacit Indian backing won control of the provincial council in November 1989 by an impressive showing of support in the East while winning the North by default as there was no contest in these areas. The new Muslim party, SLMC, won 17 seats and the UNP one. The 64% voter turnout in the East has been described "as a snub to the LTTE whose boycott call was not fully followed. On the other hand, it is viewed as a reflection of the people's genuine desire to express themselves through the democratic process, for peace and end to armed violence" (Tamil Times, 1988)

In the General elections held in February, 1989, the EROS(Eelavar Democratic Front) scored a spectacular success, winning a majority of 13 seats in the North & East indirectly showing grassroot support of the LTTE in the North. The TULF-EPRLF-ENDLF-TELO alliance won 10 seats with all the TULF stalwarts losing their seats. Amirthalingam was appointed on the National list but was assassinated together with the ex-MP for Jaffna, Yogeswaran, while involved in negotiations, allegedly by the LTTE. The LTTE opened direct talks and reached an agreement with President Premadasa's Government who then demanded the withdrawal of the IPKF.

The EPRLF proceeded to recruit and train a large army (Tamil National Army) and passed in the Provincial Council, a Unilateral Declaration of Independence (UDI) of the Tamil areas, The compulsory conscription of youth and other delinquent activities increasingly alienated the pro-Indian groups from the people, while strengthening the grass root support for the LTTE.

The general elections, despite reported malpractices such as 'rigging', 'ballot stuffing', and 'intimidation', nevertheless established the Sri Lankan voters' preference for the electoral process. A significant proportion (though lower than the usual high percent of 80%) turned up to exercise their vote, braving JVP threats, and thus their rejection of violence for peaceful process.

With the killing of the JVP leadership in November 1989, the Sri Lanka Army was again

freed to turn its attention to the North and East of Sri Lanka. It would appear that we had come back a full cycle, after all the death and destruction, to the beginning. But much blood has flown under the bridge and the people are extremely weary of the killing and devastation. They cried out for a respite. It was hoped that their leaders too would recognise this desperate need and sue for peace. Tragically this was not to be.

The Civil War continues

> *"Victory breeds hatred. The defeated live in pain. Happily the peaceful live, giving up victory and defeat."* **-Buddha, Dhammapada 201**

With the withdrawal of the IPKF, the LTTE took over the vacated areas. In the East the ill-fated Tamil National Army left behind by India, was no match for the more experienced and determined LTTE. They had often been forcefully conscripted in collusion with the IPKF. Many were adolescents, their motivation was extremely poor, and they had been poorly trained. The LTTE literally mowed them down and captured all their weapons. Other groups, dissidents, and even those suspected of being unfavourable to the LTTE suffered the same fate. The Sri Lankan forces helped and encouraged this process starting from early 1989 during the Indian presence, by providing the LTTE with arms, transport, air cover and logistic co-operation, for example, the arrest and transport of those thought inimical to LTTE interests from the south.

The short lived honeymoon with the Sri Lankan State soon ran into trouble. Negotiations broke down when President Premadasa tried to introduce other Tamil groups through the All Party Conference when talks with the LTTE started going badly soon after the IPKF left the country in March 1990. The LTTE had always been very sensitive to the inclusion of other Tamil groups in any negotiations, or any process whatsoever. They wanted to be solely in power. The government also was very slow in repealing the Sixth Amendment to the Constitution. The State forces, confined to barracks, became very restive and tensions with the LTTE rose. They had succeeded in wiping out the JVP and were brimming with confidence, eager to do the same with the LTTE. The LTTE felt it had 'chased out the fourth largest army in the world and wiped out their proxies, the Tamil National Army'. Friction and incidents followed each other to soon break out in open hostilities in June 1990. The marriage had been purely one of mutual interest, that of getting India out.

It may be pertinent here to ask why the country went back to civil war, after the obvious relief and high hopes shown by the war weary people of Sri Lanka. The only answer is

that there had been built up over time considerable interests and investment in the continuation of the war, in the political and military leadership of both sides and some business establishments, both local and foreign (e.g. arms traders, dealers in essential items). But apart from the vested interests involved in economical gain, position (military) and power, it was the psychological investment in violence and conflict milieu that was instrumental in pushing both parties towards war. It was war they understood best, were comfortable in, and were familiar with. It was the conflict situation that they were able to manipulate to their advantage. On the other hand, peace was threatening, where social and political forces, particularly democratic and plural mechanisms, that they could not handle would take over. Significantly, the adversaries understood each other, knew the game plan and how to play it. Some of the soldiers and militants had become addicted to violence and they pushed for resumption of war to which they were used.

It was tragedy for the Tamils people, particularly in the East, where they had already been through much suffering. Many begged the IPKF not to leave. But this choice to go back to fighting by the LTTE leadership, exposing the people once again, was to be repeated time again, to no purpose, no real gain. This was how they had learned to live and think. While some adroit diplomatic and political manoeuvring would have achieved much more and consolidated previous gains. Unfortunately, the LTTE lacked this skill. Understandably they were wary of negotiations where they were afraid, not without reason, that they would be easily tricked by the more wily politicians who were more adept at intrigue and diplomatic double talk (Perera, 1997). Yet, it was loathe to let someone else take over this role and thus the leadership or power over the Tamils. The costliest mistake for the Tamils as a whole had been antagonising India, for all the high handedness and personal insult to Prabhakaran. For India had negotiated a modicum of self-rule for the Tamils under a federal set-up and was obliged to guarantee its implementation. Perhaps the country was not yet ready and such solutions cannot be imposed from the outside.

Many of the police stations in the East were surrounded by the LTTE, and policemen surrendered on the orders of their superiors in Colombo. Hundreds of policemen who were Sinhalese and Muslims were executed by the LTTE. As the Sri Lanka forces then advanced to bring the area under their control, the LTTE made a hasty retreat without offering resistance. Thus, ordinary civilians were left exposed and vulnerable.

Elizabeth Nissan (1996) summarises what followed:

"With the southern counter-insurgency operations completed, the military was swiftly moved back into the East after these attacks to regain territory from the LTTE. In the

first months of the war they employed tactics similar to those they had recently used in the South; thousands of people were killed and disappeared in custody as the army sought to take, and consolidate control over, the main towns and communication routes in the East and in Vavuniya and Mannar. Many people were taken from their homes by the military never to be seen again. Young men were particularly vulnerable to being killed or disappeared in custody; but older men and women, young women, children and babies were also among the victims. Even refugee camps provided no secure place of refuge: in several instances, well over 100 people at a time were taken by the military from the camps and could never be traced again. Burnt and mutilated bodies were displayed on the streets; unmarked vehicles roamed the towns, their occupants abducting people at will". People fled to the jungles, some dying from hardships like snake bite and starvation.

Relations between the Muslims and the LTTE deteriorated rapidly thereafter. Starting with the killing of the Muslim policemen, there were several massacres of Muslims, including 70 bus passengers, 120 in the Mosque at Kattankudi, 121 at Eravur and individual civilians like Dawood who had been working for Tamil-Muslim unity. Massacres were also conducted in many border villages. It is reported that some local LTTE leaders were against the killing of Muslims but they were overridden (UTHR-J,1994). There were also Muslims among the LTTE cadre but they soon escaped. The outraged Muslim parties like the SLMC urged the government to arm the Muslims, and the State created a Muslim Home Guard, similar to the Jihad which had been operating from 1984. "In practice, however, home guards had proved of little use in defending civilians. They had been easy targets for experienced fighters, but had terrorised defenseless people. In most instances, instead of preventing violence they added to it, and their action worsened ethnic tensions" (UTHR-J, 1994) "Numerous instances were reported of abuses committed by the Home Guard, including widespread killing of Tamil villagers in reprisal killing of Muslims by the LTTE" (Nissan,1996) The Sinhala Home Guard, created for the same reason (i.e. to defend Sinhala border villages) proved to be no different.

By October, 1990, all Muslims living in the North, estimated at 120,000, were expelled by the LTTE. They were given a few hours to leave and allowed to take only a small amount of money. All their property was confiscated, but some wealthy businessmen were kept back till a ransom was paid.

The LTTE took control over most of the North. There were some large scale attacks by the LTTE, sometimes taking on a conventional dimension. Some of the army camps

were overrun-Mankulam, Kokavil. Some the army vacated-Killinochi and Jaffna Fort-after a long siege. Some resisted strongly with heavy casualties on both sides as in Elephant Pass and Silvathurai. Some camps were captured and then vacated or retaken-Janakapura in Manal aru, Poonery, Manadathivu and Mullaithivu with heavy losses to the security forces. The LTTE seemed to have perfected the art of mass, overwhelming attacks, where hundreds or thousands of their cadre, including suicide units with explosives strapped on to their bodies, suddenly attack in waves until the enemy loses nerve. Once this critical psychological break occurs and the forces turn their back, they are able to overrun the camp. There were some spectacular sea battles and the LTTE brought down several planes with missiles. The Sri Lankan Forces also launched several combined (Army, Navy, Air Force) operations in the North-Operation Major to take the islands, Operation Yal Devi to take Kilali, and recently Operation Riviresa to take Jaffna, and Operation Jayasikuru to open a land route to Jaffna through the Vanni, in addition to several smaller ones. The LTTE suffered heavily in its multi-pronged attack in Manal aru and at Neerveli in July and October, 1995 respectively and Paranthan in 1997. All this military activity resulted in considerable casualties to the combatants as well as to civilians. The killing by bombing of 120 fleeing civilians taking refuge in precinct of the Navaly St. Peter's Church, was a stark reminder of reality. Many were to perish by indiscriminate shelling. The LTTE is said to have been responsible for several assassinations during this period, some by suicide bombers. Prominent among the assassinations were the complete Central Committee of the EPRLF in Madras in 1990, the Sri Lankan President, R. Premadasa, and the UNP Presidential candidate, Gamini Dissanayake. Perhaps more important for the course of the whole war was the death of General Kobbekaduwa and other top commanders in a land mine explosion just before their Jaffna offensive. For the LTTE, apart from losing some of their top leaders in battle, they lost Colonel Kittu off India and Deputy Leader Mahathaya, reportedly executed on charges of conspiring with the Indian RAW.

The LTTE carried out several suicidal attacks in Colombo during the period-the oil tanks, Central Bank bombing with 90 civilian deaths, and the port being among the later ones.

A stalemate had been reached by the end of 1990 and there appeared an unspoken agreement that the Sri Lanka State controlled the East and the LTTE the North. The LTTE set up a complete parallel government. As before, the Sri Lankan Government continued to pay all the salaries and send relief food, medicines and essential items, almost all from foreign aid. The LTTE controlled the day to day running. They also set

up ambitious community projects and development programs, particularly under the Tamil Rehabilitation Organisation, TRO. The planting of trees, a ban on cutting trees, the reclamation of ponds and irrigation channels; development programs for alternate energy sources, small scale industries, large farms, nutritional centres, special training programs, and resettlement schemes in model villages, were launched with much enthusiasm. An elaborate tax system with protection for local products was introduced. (There was a strict embargo on most items imposed by the Sri Lanka State-such as fuel, medicine, fertiliser, and so on; there was no electricity from 1990, as well as almost no postal services). Two compulsory fund collections by the LTTE were carried out. The first was payment of two sovereigns or Rs.10,000 by every family. The second was based on the assessment of family assets, for example number of children abroad, and sometimes involved large sums. Some of the elderly suffered from heart attacks during the assessment procedure and the fixing of sums to be paid. Psychological reactions were marked as many felt humiliated and let down by the system they had supported. A judiciary system with courts, judges, free lawyers, and a police force to maintain law and order were established. The system worked efficiently and quickly for most minor offences, such as the perennial land disputes, unlike the earlier system. There was well publicised action to protect women against harassment and the dowry system was banned. But for all this, it remained a totalitarian regime. Human Rights were unheard of. Everything was under tight control-from the mass media to what can be said and even thought (see Chapter 8). Dissenters were treated severely.

Chandrika Bandaranaike Kumaratunga, daughter of two Prime Ministers and wife of slain charismatic political leader Vijaya Kumaratunga, rose rapidly to power within a short period, winning democratically the elections to the Provincial Council in May 1993, the Premiership in August 1994 and then the Presidency a few month later with a resounding majority. She won the hearts and votes of the people with a campaign to end corruption, the Presidency and the war and was supported by liberal activist groups and a groundswell of popular sympathy. Not only the Sinhalese majority but the minorities too voted overwhelmingly for her. On assuming office, she opened talks with the LTTE, agreed to a cease fire and lifted the ban on most essential items to the North. But the talks floundered. She was not able to meet those demands of the LTTE, which though purportedly for the benefit of the people, would have given the LTTE a military advantage, and the LTTE refused to talk about the main political grievances and their resolution. When the LTTE began the war once more in a sensational way, Chandrika lost her peace

initiative and the military logic took over. Initially the LTTE sank Naval boats with suicidal attacks, and shot down Air Force planes reportedly with newly acquired missiles. The war entered a completely higher dimension, with greater destructive power and more misery for the people.

Chandrika did show some progress in cleaning up corruption, and setting up various inquiries into past misdemeanours, and attempted to improve Sri Lanka's Human Rights Record. Years of painstaking and costly work by human rights advocates and pressure from the international community appeared to be paying off. Initially the number of disappearances, torture, extra-judicial killings etc. appeared to decline and the international community was satisfied. But for all that, she has not been able to bring about a qualitative change to the armed forces, although atrocities by the ground forces, have declined in recent years. No one has so far been sentenced or punished despite considerable proof furnished during court Commission proceedings. Rather the procedure all along has been to transfer or promote those guilty. Perhaps the mass graves found in the South cry out for justice, but some of those under the court proceedings (Daily News,1996) have been recently promoted to Major Generals (Island,1996). Although there was considerable evidence linking them to mass killings, and the President did attempt to send them on compulsory leave as reported in the press (Sunday Leader,1996), she could not cross the military. More ominously the number of disappearances in Jaffna topped 600 in one year, the highest for the world. In the same way, when the elite STF was linked to the bodies that had started appearing in the lakes in Colombo during mid 1995 and their headquarters in the heart of the city was implicated as a torture chamber (Counterpoint,1995), those under suspicion were released and the case closed. The recent massacre of 24 villagers, including children and women, and the rape of women at Killiveddy was another test case for the new government as the commander too is implicated (UTHR-J,1996). As long as members of the forces continue to enjoy impunity for the atrocities they commit, these 'lapses' will continue, and the Tamils will not regain confidence in the State or forces. Although the Political Package to solve the ethnic problem promised considerable devolution of power, went a long way towards addressing the grievances of the minorities, and was more than any Sinhalese leader had offered so far, there was, understandably, doubt whether it would be watered down. Further, Tamils learned from bitter past experience that such accords have never been passed or meaning fully implemented. The harassment of ordinary Tamil civilians in the South, and the general negative attitude towards them that had been created quickly alienated this group that had looked to her with hope.

The LTTE carried on with what it knows best-war. The exodus of the whole population of the Valigamam area, estimated variously at 500,000, the closing of all the major institutions including the University and the Jaffna Hospital and the suffering of the displaced, caused considerable resentment of the LTTE's role among the people involved. There appeared to be some resistance to pressure from the LTTE. With the completion of Riviresa 2 and the capture of the rest of the peninsula, those displaced went back to their homes and tried to rebuild their lives from the ruins. But as long as both forces continue to think and act along military lines, the people will be mere pawns foredoomed to suffer in mind and body. A clear indication of this was the number of people fleeing to India despite the very real dangers inherent in crossing by boat.

In this atmosphere the chances for peace seem dim indeed. The military logic may have to run its course till everyone in the political and military leadership gets tired of war, before we can start thinking of peace. Nevertheless, with outstanding statesmanship like in so many parts of the world today, where there have been what seemed to be intractable conflicts, a willingness to give in on some issues, and perhaps more important, to allow the voice of the war-weary people to be heard to inform the search for peace, to override the political, military and militant interests, may help the birth of sanity from the ashes of the death and destruction of this cruel war. Then we may be able to fashion a peace even at this late hour. The purpose of what is to follow is precisely that: to bring out the mental suffering of ordinary people and even the ordinary members of blind armies that clash in ignorance, to create a much needed psychological space for peace.

REFERENCE FOR CHAPTER 2

1. Amnesty International (1985). Sri Lanka: File on Torture AI Newsletter, October, 1985.
2. Amnesty International (1986a). Disappearances In Sri Lanka. ASA 37/08/86, September, 1986.
3. Amnesty International (1986b). Sri Lanka: Some Recent Reports of Extrajudicial Killings, Sept, 1985 to March, 1986. ASA 37/03/86, April, 1986.
4. Amnesty International (1987). Sri Lanka: Recent Reports of Disappearances and Torture. (May, 1987), ASA 37/09/87.
5. Counterpoint (Nov, 1995). 0f Rotten Apples and State Terror: The State of the Art in STF. Author, Colombo.

6. Daily News (Jan 16, 1996). Colombo.

7. Gupta, Shekhar 'It Was a rush to Vanquish', India Today quoted Sunday Times 31. 1.1988. Colombo.

8. Hoole, M.R.R.,Thiranagamma, R., Sritharan, K., Somasundaram, D.J., (1988). Broken Palmyra. Harvey Mudd College Press, Calfornia,USA.

9. Hyndman, Patricia (1985). Democracy in Peril: Sri Lanka, a country in crisis. Report to the LAW ASIA Human Rights standing committee, June, 1985.

10. India Today (1988) Indin Army Underestimated LTTE, (15.5.1988). India.

11. International Center for Ethnic Studies (1987). Report of a trip to Batticaloa (Eastern Province). Aug 14-16, 1987. Colombo.

12. Island (1996) (April 16, 1996). Colombo.

13. Murasoli (1988) Kandasamy Will not be Seen, 12.7.1988. Murasoli Publishers Ltd, Jaffna.

14. Nissan, E. (1996). Sri Lanka: A Bitter Harvest. Minority Rights Group, London.

15. Perera, J. (1997). The Vulnerability of Rebel Organizations. Sunday Island, May 25, 1997. Colombo.

16. Piyadas, L. (1984). Sri Lanka Holocaust and After. Marram Books, London.

17. Rubin, B. (1987). Cycles of Violence. Washington: Asia Watch, 1987.

18. Selbourne, D. (1988). An Exhange of Letters on Kanthasamy, Tamil Times,VII:11. p13-15. UK.

19. Sunday Leader (1996). President's letter to Army Commander. (March 3, 1996), Colombo.

20. Swamy, Narayanan, M.R. (1994). Tigers of Lanka I From Boys to Guerillas. Vijitha Yapa Colombo.

21. University Teachers for Human Rights (Jaffna) (1994). Someone Else's War. Movement for Interracial Justice and Equality, Colombo.

22. University Teachers for Human Rights (Jaffna) (1996). Trincomalee District in February, 1996: focusing on the Killiveddy Massacre. Information Bulletin No.1, Author, Colombo.

23. Weaver, M. (1988). A reporter at Large. The New Yorker, Mar 21,1988, New York.

Chapter 3

Psychological Causes of War

"Wars begin in the minds of men"

-Constitution of the United Nations Educational Scientific and Cultural Organisation (UNESCO)

Introduction

War is a behavioural pattern reflecting a state of mind. The aforementioned socio-economic deprivation or historical processes have to work through the human psyche, to influence emotions and thinking to provoke a violent reaction. It is only when people are led or cornered to believe that war is the only solution to their problems that they are willing to fight. It is here that the ability of power-hungry leaders to manipulate the socio-economic and historical forces, to arouse people through propaganda and demagogue come in (Allport, 1950).

For people to be pushed into war, to sacrifice their material, physical, psychological, social and spiritual wellbeing for a predetermined cause, basic psychological processes have to be activated and manipulated towards this end. This is not to deny the realities of injustices and inequalities; the violence of social oppression and political repression or economic deprivation. But how are these problems deemed unsolvable without war? Instead of addressing these fundamental problems realistically and practically, people's attention is distracted away from the real source on to scapegoats and war made to appear as the only inevitable and final solution. Frustrations and discontent are harnessed towards this end by appealing to ultimate loyalties and patriotic duty by arousing deep passions. Yet far from solving problems, war makes the situation more complicated and intractable. Except for a few political and military leaders as well as business entrepreneurs who make a quick profit, war is an unmitigated disaster for the majority of people. With massive death and destruction, the economic and social cost, war, in addition, sets in

motion hostilities, suspicions and a thirst for revenge, that will take generations to work their way through. Thus, instead of imposing any permanent solution, war sows the seeds for more conflict and polarisation.

It is often argued that biologically and historically man has an innate propensity towards war. According to Freud, there is a drive or instinct for aggression or destructiveness in man called thanatos. Civilised man's need to repress his destructive nature results in periodic outbreaks of conflicts and war (Freud, 1961). But biologically in the animal kingdom, there is no evidence of such an inherent tendency, for man is the only species that kills its own kind in such numbers, with such cruelty and abandon. Inter-species aggression is very rare in the animal kingdom except in a prey-predator relationship(i.e. for food), and intra-species aggression takes place only during natural feeding and breeding, where it is defensive, and adaptive (i.e. furthering the survival of the species). The aggression is over territory (serves to space out individuals) and hierarchical (to establish social order for mating, feeding, defending and leading). Such aggression, usually falls far short of actual fighting, often expressed in ritualised displays and threat intention movements and rarely ever ends in killing (Mathew, 1964).

Identity

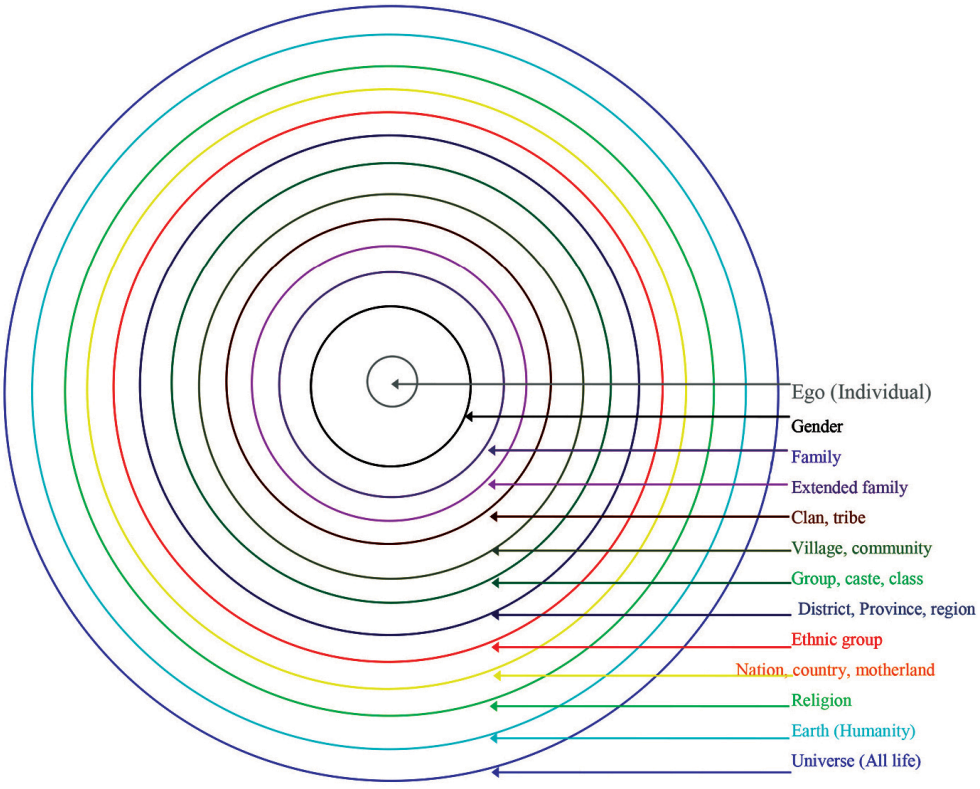


Fig.1
Increasing group identification-Modified from Allport. (1958)

The central factor in the ethnic conflict in Sri Lanka as in many parts of the world (the old USSR and Yugoslavia; India, Cyprus, Rwanda, N. Ireland and Spain) has to do with group identity. For it is the feeling of belonging to an ethnic group and the struggle to maintain this identity that was the basic cause for the present war. It was the assertion of the Sinhala-Buddhist identity of the majority, using the state machinery at the expense of the minorities, that led to the growing reaction to save the Tamil identity. Thus, the driving force behind the confrontation has been the two ethnic identities-Sinhala and Tamil.

Identity consists of the beliefs, values, capacities, character traits and nature, that go into making an individual's personality. The various roles in life-gender, occupation, family, social, how one perceives oneself in relation to others, and feeling of duties to self, family and society are parts of an identity that functions from deep within, at the core of one's being. Group identity is based on a shared way of life, social norms, beliefs and values; caste or class; language and religion-in short a socio-cultural identity. It may also stem from the area of inhabitation-the homeland, whether it be village, district, region or nation, in other words territorial identity. Ethnicity refers to large grouping based usually on a shared way of life, culture, language, religion or territory.

The feeling of belonging to a group, of being a member or part of a larger social unit, of having roots that reach deep into the soil gives nurturance, warmth, solidarity, security, positive self-esteem, self-respect and wholeness. Very often a group identity will be in reference to other groups that includes perceived differences, attitudes, prejudices, stereotypes and comparisons which can be positive or negative.

When this identity and belonging is threatened, it strikes at the very core of the being evoking anxiety and a deep sense of insecurity. Thus, it is no surprise that individuals and groups will react with considerable emotion and fight with a survival instinct as if their very group life was at stake.

This desperate effort to save a threatened identity or change a negative social identity does not necessarily take a violent turn. There may be passive acceptance of the state of affairs or individuals may move out of the group (migrate) and assimilate or adopt another group identity. Alternatively, members may work constructively to elevate social identity by popularising movements to enhance their language, religion and culture, to create a positive image and dignity. In-group pride and assertion leads to positive social identity and is a useful mechanism of changing negative self-image and righting existing disadvantages, discrimination, exploitation and repression against the

group. Because the elevation of social identity can change comparison groups and the perception of justice, it is a revolutionary act (Brown, 1986). Introduction of cognitive alternatives leads to questioning the legitimacy of the prevailing relations between groups, a rejection of the status quo, and outbreak of conflict (Tafjel, 1978).

Due to the powerful emotional charge involved, such challenges often end in confrontation and conflict particularly when obstructed or suppressed violently in situations of inter-group tensions, perceived injustices and inequities. Unfortunately power hungry leaders and demagogues are well versed in the art of cleverly exploiting this reservoir of potentially explosive energy and turning it to their own purpose by appealing to patriotism, language, religion and such mystical concepts as soil and blood. Such appeals have the power to strike deep chords in one's being evoking ultimate loyalties and irrational passions, called 'militant enthusiasm' by Konrad Lorenz (1963).

Inter-group conflict and war becomes an easy means for opportunistic leaders to acquire, or continue in power. But in all fairness, it must be pointed out that the leaders themselves are not consciously aware of what they are doing and they themselves are caught up in their own rhetoric and the passions and loyalties they evoke, genuinely feeling they are acting for the good of their group.

When we look at the situation as it developed in Sri Lanka, the emergence of the Sinhala-Buddhist identity, described in detail by Gunawardena (1990) and Kumari Jayawardene (1986) was a gradual development but took its current form only from the end of the last century. It started initially as a reaction to the proselytising Christianity of the missionaries in particular and Westernisation in general which threatened the Buddhist identity of the Sinhalese. This developed into a movement led by Anagarika Dharmapala and was later taken up by other aspiring Sinhala leaders. The popularisation of Sinhala-Buddhist identity took place through popular meetings, literature, mass media, political demagogue and anti-minority conflicts, against, in chronological development: Christians, Muslims, Indian Tamils, Malayalis and finally Ceylon Tamils.

The Sinhala-Buddhist identity or consciousness is based on :-

1. "The doctrine of the primacy and superiority of the Sinhala 'race' as the original, true inhabitants of the island, linked to the myth that the Sinhala were 'Aryan' migrants from Bengal". (Jayawardena,1986)
2. 'The concept that the Sinhala race has been placed in a special relationship to Buddhism as its protector.' Appeals to save Buddhism from infidels or non-Buddhists have

been resorted to, and in recent years it has gone as far as calling for a 'dharma udhaya' (Holy War) to protect Buddhist movements and the religion.

3. "The feeling that the Sinhalese (and also the Sinhala Language) are really a minority in the region with no other country except Sri Lanka, unlike the other minority groups which have ethnic links with other countries", particularly, a minority in reference to the 50 million Tamils in South India (Jayawardena, 1986). There is a fear, a minority complex on which this is based.

The construction of the Sinhala-Buddhist identity based on 'race, religion and language' which is perceived to be threatened by the 'alien' Tamil 'invaders' from South India has had a profound influence on the Sinhalese people, spurring them to action, politically and violently against those that it was told threatened this historic identity. It was this appeal to the core identity of the Sinhalese by the upcoming parochial leaders that provided the driving force to unseat the English educated national elite in 1956, and made the majority governments undertake affirmative action to correct perceived 'historic' injustices to Sinhala Buddhism. These strong feelings were to grow into virulent Sinhala Buddhist chauvinism from 1956 and culminated in the 1983 race riots.

The Tamil identity developed mainly as a reaction to the increasing dominance of the Sinhala Buddhist identity (though there had been a short lived Hindu revival led by Arumuga Navalar in the last century as a response to the Christian Missionaries). As successive Sinhala leaders rose to power by exploiting emotions relating to Sinhala-Buddhism and then proceeded to use the State machinery to enforce Sinhala as the only language (1956 Bill), enshrine Buddhism as the State religion (1972 constitution), discriminate in favour of the majority Sinhalese in education, employment, allocation of resources and land (colonisation), and encourage periodic mob violence ('56, '58, '77, '81, '83) against the minority Tamils, they in turn began to fear that their very identity, cultural existence as a separate and unique group was threatened.

Thus, although the Tamil identity crystallised more in opposition to the threat from the State, yet it was not a de nova synthesis. Language was the vital element of the Tamil identity, with territory, a homeland in the North and East of Sri Lanka forming another aspect. Though not stressed by the secular youth, Saivaite Hinduism was also as much a part of the Tamil identity; perhaps more so as part of the general Tamil culture.

It was the elder generation who first gave voice to the increasing insecurity, the reaction taking 'moderate' political form. The elders' arousing rhetoric of the principles of self-determination, autonomy, freedom, separation and the virtues of Tamil nationalism,

fired up the idealistic youth but failed to achieve any positive results in the face of increasing persecution by the State.

They were in time debunked from the leadership as too compromising, accommodative and submissive. It was left to the youth to redeem the Tamil identity and honour, to take up the mantle and meet the challenge for group survival with a violent defiance. It was the educated youth that felt most the closing of the doors to higher education and occupational opportunities. When in the 1983 riots Tamils as a group were humiliated, the youth took up arms to prevent a complete eclipse of the group's identity. That they did so in thousands with complete dedication, determination and resourcefulness is a mark of the deep threat that was felt at the core of their beings, a fear for their identity as a group.

The crucial role of the youth in the Tamil 'identity crises' and the subsequent ethnic war can be understood from a study of the psychology of identity formation. According to Erikson(1968), the process of identity formation has its normative crisis in adolescence. Identity develops from childhood through successive psycho-social stages to culminate in youth. During this orderly development children are socialised to become adult members of the group by parents, relations, peers, teachers, schools, religious and political leaders; myths, superstition and gossip and mass media such as TV, radio, cinema, video, magazines, books and newspapers. Children learn or unconsciously imbibe the various aspects of their culture and relationships among themselves and other groups. During this complex and subtle process, historical events as they effect the group (for the Tamils, the gradually increasing socio-economic and political pressure, the periodic racial riots and repression) would influence the growing children. The fears, wishes, fantasy, resentment, anger, bitterness and frustration (much of it unconscious) of parents and group would be passed on to the growing child. The phenomenal success of the dominant Tamil militant group, the LTTE, to win the continuing support of a segment of the population and attract a large number of dedicated youths into their ranks has been their ability to identify themselves with the Tamil Socio-cultural identity and represent Tamil nationalistic fears, suspicion and aspirations at its deepest and fundamental level. Thus, the LTTE became the ideal, the alter-ego, acting out the inner longings, wishes and paranoia of the Tamils.

These various forces and experiences culminate in adolescence when youth attempt to synthesise these elements into a definite identity to carry them through the rest of their life. Thus, adolescence becomes a period of intensive searching for meaning; experimentation with role models; oscillation between extremes; challenging parents, authority and

institutions; commitment to 'issues' of diverse ideologies, a time of questioning and defying and defining adult, cultural and social values, attitudes, belief systems and institutions. The full energy, resourcefulness and exuberance of youth is directed towards establishing a consistent and genuine identity. Erikson(1968) describes the social function of youthful striving: "This drive for fidelity, search for genuineness and unselfish commitment to altruistic values serves the function of regenerating society. In youth, the life cycle intersects with history: here individuals are confirmed in their identities by society and societies regenerated for a coming generation."

Tamil youth dedicated themselves wholeheartedly and with full force of their youthful energy to the historical task of saving their threatened community, of regenerating the Tamil nation. They felt let down by the elder generation who did not live up to the idealised image they presented. The rejection and death sentence carried out on the elder politicians is a reflection of the youthful tendency for extreme solutions for what they see as wrong or false. In all fairness, the elder generation were attempting to solve the problem in the only way they knew how.

The youth took up the challenge of fighting the powerful State and redeeming their society with enthusiasm and courage. Initially there was altruism and hope. Tragically the youthful revolution soon split into diverse groups, professing various shades of social ideologies, following different leaders, to culminate in suicidal internecine fratricide.

Another feature of the period of identity formation is that once youth commit themselves to a particular group they become extremely 'clannish', intolerant and cruel in their exclusion of other groups, while fledging total and blind obedience and loyalty to their own group. This process of in-group formation and exclusion of any out-group was brought out by a series of elegant experiments. When subjects are assigned to a group, any group even arbitrarily and at random, they immediately, automatically, almost reflexively, think of that group, as an in-group for them, as better, attributing positive qualities and showing in-group preferences. To them any alternative is an out-group, attributing negative qualities and showing discrimination against them and depriving them of resources even when it is clearly detrimental to their own interests(Brown,1986). This kind of group formation was clearly seen among the Sinhalese and Tamils. Formed on the basis of extreme nationalism each group attributed or projected on to the stereotyped 'enemy' a malevolent intent. However, these bigger groups have disintegrated into bickering smaller groupings. Among the Tamils the fanatical loyalty and bitter hatred for other Tamil groups have foredoomed any prospects of unity, even denying a semblance of power sharing. Ironically the Tamil groups have shown much more

intolerance, hatred and cruelty towards each other, branding the out-grouper as traitors or anti-social, than for their 'traditional' enemy the Sinhalese or the Indians.

Erikson (1968) clearly predicted that when group identity is threatened and youth rebel on a large scale the older generation also fixate on adolescent alternatives, a greater number fall in line or are paralysed in their resistance. The older generation abdicates too willingly and too quickly their vital roles as sanctioners and critics. In the North the youth took over the role of running the society, making the decisions and determining social activity. The older generation that was left, passively acquiesced to the new dispensation, some, in particular; religious leaders and academics became public apologists to rationalise the spreading violence of the youth. Thus, the militant movement among the Tamils was basically a phenomena of youth linked to the tumultuous period of identity formation.

With the passage of time, the few early youthful leaders who survived have passed middle age and the pattern of recruitment into the Tamil militants too is changing in terms of age, sex and motives for joining. It is no longer the altruistic youth, many of whom have left or been killed while those remaining have grown increasingly disillusioned; but children just reaching adolescence who are still plastic in their identity formation and thus amenable to indoctrination. There was a horrific period of forced recruitment under the Indians for the so-called Tamil National Army. Later older children and adolescents were encouraged to join the LTTE voluntarily, though this term can be misleading in the context of the age where a clear volition or independent thinking has not matured. The attraction for some of them may be the thrill of adventure and more a 'Pied Piper' effect. For younger females who experience the widespread socio-cultural oppression against their sex, it is a means of escape and 'liberation'. Political repression, socio-economic deprivation, frustration in life and fear of the enemy have become prime motives if not compulsion for joining the militancy in many youngsters.

It should be noted in this context that other minority groups too have recently begun to assert their own identity. One is the Muslim community which has seen a rapid political awakening, forced more by the circumstances of ethnic hostilities. A fundamental militant organisation of youth, Jihad, and political parties have surfaced to represent Muslim interests and with the electoral success of the SLMC (Sri Lanka Muslin Congress) lay claim to the rights of the Muslims to an autonomous region of their own in eastern Sri Lanka. The other potentially revolutionary group that has been gaining a positive identity, shedding its negative self-image maintained under years of exploitation, is the Hill Country Tamils. Here again it's the educated youth who have taken the lead. It is

worth mentioning that the JVP rebellion in the South has also been a youth phenomena. Kumari Jayawardene (1986) ascribed the impetus and support for the JVP as coming, despite the rhetoric, from the Sinhala Buddhist consciousness. There can be no doubt that the main reason for the emergence of the JVP after 1987 was the threat to the Sinhala Identity, particularly its territorial integrity from the intervention of India (for whom there is supposed to be a 'racial' memory of repeated invasions in history). Significantly the JVP drew its main support from the deep South, among discontented Sinhala youth, and lost steam when the Indians pulled out.

It is interesting that one of the reasons put forward for the ethnic polarisation and conflict in Sri Lanka is a lack of a true Sri Lankan national identity. There was no struggle for independence from the British to speak of, what there was never reached a mass level, and never involved the development of an all-island national identity as it did in India. Even among the elite who sued for a respectful, moderate self-government, the national front soon split into bickering, ethnic factions. It has been argued that it was precisely the Western theories of race popular at that time, and the Colonial governance based on race that led to the construction of ethnic identities as we see them today (Arasaratnam, 1970). The practical need to divide the loyalties of the colonial subjects and prevent a forging of a united opposition would have also played a role.

Worldwide, we have seen in the 20th century the growth of nationalism and ethnic differentiation unparalleled in history. This vigorous affirmation of distinctions and separatism has meant struggle for self-determination and autonomy. In-group pride and cultural assertion cannot be constrained to follow just the boundaries that those who helped to create them may have wished. Frantz Fanon (1967) worked to create black African identity but what ensued is a host of national and even tribal identities, a veritable Pandora's box.

The dangers of too much differentiation and exclusiveness are only too clear for us to see today-that is the problem of ethnocentrism and chauvinism. This is the tendency for the positive elevation of group identity to progress to the extreme position of the group thinking itself special and superior to all others as happened in Nazi Germany.

Erikson (1968) describes this need for a psychosocial identity, both personal and collective, to be a 'special kind': "To reinforce the illusion of being chosen, every tribe recognizes a creation of its own, a mythology and later a history; thus was loyalty to a particular ecology and morality secured. Other tribes came to be useful as a screen of projection for the negative identities which were necessary, if most uncomfortable, counterpart of

the positive ones. This projection, in conjunction with their territoriality, gave men a reason to slaughter one another in majorem glorious."

Thus, we have the Mahavamsa reassuring the Sinhalese king Duttugemunu that is not sin to kill Tamils 'for them are less then human beings' (Geiger, 1950).And we have the father of the nation, D.S.Senanayake(1939), addressing a rousing appeal to the Sinhala people:

"We are one blood and one nation. We are a chosen people. The Buddha said that his religion would last for 5500 years. That means that we, as the custodians of that religion, shall last as long."

Reggie Siriwardene(1984) commenting on the 'mystical belief in blood' in the racist vocabulary to denote racial purity, says. "If you really believe that your blood is inherently superior to that of another race, you will have less conjunction about shedding the latter". The growth of Tamil nationalism (which began as a reaction to Sinhala domination) leading to chauvinism and linking to a Pan Tamil Nationalism, is already apparent, here and across the strait in Tamil Nadu. Voices supporting the establishment of a separate Tamil Eelam state refer to the purity of the Dravidian race, descendants of the ancient Mohanjardo civilisation, the greatness of a 5000 years old Tamil language and the glories of the Chola empire. The powerful Tamil militant group, LTTE, have adopted the Chola tiger emblem to represent and appeal to extreme Tamil nationalism. The dangers of an ethnocentric, exclusive national identity alienating minorities within Tamil-speaking areas is already seen in expulsion of the Muslims. Eastern Tamils, who have been traditionally treated demeaningly by their Northern brethren and feel that their identity, history, culture and problems are somewhat different, voice fears of being over dominated by the Jaffna Tamils (Reddiar, 1997).

Although scientifically, ethnicity can be understood on the basis of a common way of life, language, religion or territory, membership of an ethnic group usually bases itself in a mystical belief of sharing the same blood or belonging to the same soil. At times of ethnic identity formation and conflict, appeals to blood and soil become common in the mass media and political rhetoric as seen in the North and South of Sri Lanka. That this can arouse ultimate loyalties and sacrifice is quite clear. However, the evidence for such a basis for an ethnic group is very minimal. Allport(1958) points out, "A subtle and attractive mystery surrounds the concept of blood. There is a definition, an intimacy, a symbolic importance hovering around this shibboleth. Both family and racial pride focus on blood. This symbolism has no support from science. Race is a fashionable focus

for the propaganda of alarmists and demagogues. It is the favourite bogey used by those who have something to gain, or who themselves are suffering from some nameless dread. Racists seem to be people who out of their own anxieties, have manufactured the demon of race. Others, like Hitler, have found racism useful in distracting people from their own troubles, and providing them with an easy scapegoat".

There is no evidence that Sinhalese and Tamils of Sri Lanka belong to different races (the mythical Aryan/Dravidian split). Historically it would appear that both started from the same stock of autochthonous Vedas and Nagas and after centuries of intermarriage with migrants from India, mainly South India, the Sinhalese and Tamils share the same genetic pool (see Chapter 1). Indeed, some of the elements of identity have a mixed origin. Most Tamils were Buddhist in early history and many of the Sinhalese nobility were Tamils, while Tamil was their court language.

Thus, the growth of national or ethnic identities may have positive value in righting existing inequalities, erasing negative images and raising self-esteem by establishing the distinction and unique value of a culture. But when allowed to progress to chauvinism, it leads to perception of superiority, exclusiveness and antagonism with other groups. This inevitably results in arousing ultimate loyalties, and releases powerful passions and irrational thinking that end in ethnic conflict and violence.

There is a need to break this process, to transcend exclusive, narrow identities, to encourage and adopt universal values and identification by stressing the interdependence and similarities of humanity as a whole. It is paradoxical that Buddhism and Hinduism and also Christianity and Muslim religions emphasise the need to refrain from fanatical group loyalties and exclusiveness. They stress universal brotherhood. But what we see is the very opposite being enacted in Sri Lanka. A picture of concentrically increasing and expanding identities and loyalties as given in Fig. 1 has been put forward by Prof. Allport (1958) as a way of transcending parochial identities toward a wider inclusive humanness. While recognising the uniqueness of each group and their valuable contribution to humanity, we must not lose sight of the obvious common characteristics, concerns and problems we share. After all we all belong to the same human family. We have mistaken the trees for the woods, and are paying heavily for our blindness.

Perception

Perception refers to the process, termed apperception in the older and information processing in more modern literature, whereby stimuli from the environment (external

and internal) is received, organised and interpreted. It is an active search process where attention is focused on one selected portion of information available from the environment and the perceiver uses features of the stimulus, its context, past experience and memories to generate a most likely hypothesis to fit the data. While the actual reception of external stimuli may well be the same in the sensory organ, the attention given to different aspects and the interpretation or meaning given to the stimuli (i.e. perception as defined here) differs from person to person. Further, much of social perception or consciousness is based on non-verbal cues and how these cues are perceived depend on the expectancies and mental set of the observer.

Thus, people actually perceive situations differently. Apart from selectively attending and focusing on different aspects of the situation, differences arise depending on their past experience, the context, expectation, how they define a situation and their subjective interpretation. This information processing is determined by the beliefs, attitudes, values, feelings and emotions of the individual or group. These various factors are woven together as cognitive sets or schemas which function to categorise, organise, simplify and process the enormous and complex stimuli and information impinging on an individual. We build up an internal model to represent the external world which becomes rigidified through generalisations, stereotypes and prejudices which are resistant to change despite contrary evidence. Thus, we distort all new information to fit into our preformed internal models, perceive the external world through our cognitive sets, see what we want to see and react in a habitual and set way, to determine in a direct way the universe we inhabit(James, 1890). The obvious advantage of this process is that it forms large classes and clusters based on past experience, learning and generalisation to guide and simplify our daily existence. Incoming stimuli is compared to and judged according to these preformed cognitive sets. The obvious disadvantage is that categories, though continuously modified as new experiences and information comes in, tends to be rigid and predetermine how we see, feel and act in a given situation, as it is easier to persist in old ways of thinking rather than change by an uncomfortable, painful and difficult process of altering our preformed concepts. When evidence conflicts with performed categories, the tendency is to either ignore (deny) or distort the evidence or to admit it as an exception. “Some of my best friends are Tamils but ...” “Some Sinhalese are good, but ....”. The process of deconstruction of preconceived notions thus becomes well-nigh impossible.

Attitudes have a strong affective tone attached to the cognitive schemas, producing strong likes and dislikes and result in irrational, prejudiced behaviour. A good example

of rigid categories are stereotypes, which are common beliefs and conceptions about a group generalised to every individual. Obviously, there are differences between each individual within a group and stereotypes are over-generalisation and in a sense irrational and impervious to change. Ethnic stereotypes have been shown to reflect political (cold war American Uncle Sam vs. Russian bear), economical, and social (Jews and Arabs) relations mirroring contemporary alliances and enmities, shifting as those shift[1]; but, they also appear to have stable attributes due to a particular ethnic culture and history.

Walter Lippmann coined the term stereotypes calling them "pictures in our head". Labels are powerful methods of fixing stereotypes. Of course, words help to categorise and classify diverse and complex information and help towards efficient thinking and action.

But stereotype labels usually have an associated emotional tone, often of a negative, insulting variety. Thus, the terms 'Demala' for Tamil and 'Cinkalavar' for Sinhalese are used in a derogatory way by the other group. It is of interest that the label for Tamils has recently changed to 'Kotiya' or tiger (the name of the militant group). Though still used in a negative context there is an element of grudging respect, indicating an increase in the status of the Tamil group from the customary stereotype as submissive, to those who will stand and fight. Labels paradoxically, also influence the person labelled, moulding him to fit the mould . As Sartre put it, 'the label can become an inner command' forcing the individual to behave in a way expected by others. Thus, stereotypes can become both self-perpetuating and self-fulfilling by influencing our behaviour towards those we stereotype as well as drawing out the stereotype behaviour.

These labels and stereotypes are socially supported, continually revived and hammered in by our media of mass communications-by novels, short stories, news items, movies, stage, radio, television, political demagogue and school books. Reggie Siriwardene(1984) in an illuminating study of school text books reports:

"What is more shocking is that millions of school children should be taught, in the name of social studies, through text-books published by the State, the myths of divergent racial origins which will help to divide the Sinhalese and Tamils for more generations to come." Taking specific examples (in a Sinhalese school text book) he says, "what this lesson does is to evoke the child's memories of being frightened by his parents with threats of the mysterious and fearful 'billo' to identify these bogeymen as Tamil agents, and thus

[1] The most rapid adjustment of stereotypes on record occurred in India before and after India and China had a border dispute in 1959 (Sinha & Page, 1971).

to enlist the deep-seated irrational fears of early childhood for the purpose of creating apprehension and hatred of Tamils." Referring to the exploitation of history as an instrument of decisive ethnic ideologies, he says history text books "project an image of Sinhala-Buddhist identity which is defined fundamentally through opposition to and struggles against Tamils in past history." As for Tamil text books, he quotes Professor Indrapala, "fostered in the Tamil child is a special feeling for his or her community and language, and helped to strengthen communal attitudes,....and helped to foster a kind of patriotic feeling, not towards Sri Lanka but towards Tamil Nadu". He concludes, "a system of education that encourages and fosters ideas of racial superiority and domination among the majority community is no basis for national unity or even for national peace. To adapt or sanction a two-faced educational policy by giving Sinhala and Tamil school children different conception of the relation between the two communities and their place in the national life is in fact to promote continuing discord, conflict and bitterness and to foster divisiveness and separation". In short, the educational system as it operates now creates the polarised perceptions that are the basic cause of ethnic conflict.

Minorities, especially if persecuted, tend to develop a paranoid view. This kind of attributions and expectations tend to have a wish-fulfilling effect (Argyle, 1969) leading to justification for the original suspicions and perpetuating a vicious cycle. Self-perpetuating and self-fulfilling stereotyping, leading to a vicious cycle is particularly characteristic of paranoia where one's own insecurity and suspicion is projected onto another which causes all subsequent events and behaviour to be seen through tainted glasses. This will further draw out the 'expected' response from those suspected (vide supra) confirming the original projected paranoia. In the 1920's when Tamil politicians started treating their Sinhalese counterparts with suspicion, as if they had a malicious intent, demanding a major share of representation in the legislative to safeguard Tamil interests, the paranoid outlook appears to have been fulfilled by 'Sinhalese' politicians who had till then included the Ceylon Tamils in a common identity as sons of the soil. The Sinhalese leaders then began insisting on territorial representation and perhaps only then became aware of their alleged perfidy. In time, the Sinhalese became quite wary of the Tamils, their actions became persecutory and violent, confirming the earlier Tamil fears. A closely related phenomena called the 'fundamental attribution error' is where observers tend to attribute dispositional causes to an event rather than situational causes. Tamils migrating to the South looking for jobs were seen by the local Sinhalese as a deliberate attempt to take over their jobs and business while for the Tamils, it was their particular harsh climate and geography offering poor prospects for agriculture and employment that forced them to seek employment in the South.

Another important determinant of perception is language. To a large extent what a man thinks and sees is defined by the language that is available to him. A particular culture moulds a language that is useful for the everyday living of its members. But in doing so, it utilises words and concepts that a child learns while growing up in that culture, thereby determining what and how an individual will think and see. Erich Fromm (1960) in discussing the 'filtering function of language' says: "Whether or not subtle affective experiences can arrive at awareness depends on the degree to which such experiences are cultivated in a given culture. Generally speaking, it may be said that an experience rarely comes into awareness for which the language has no word. The whole language contains an attitude of life, is a frozen expression of experiencing life in a certain way... Language, by its words, its grammar, its syntax, by the whole spirit which is frozen in it, determines how we experience, and which experience penetrate to our awareness. Every society excludes certain thoughts and feelings from being thought, felt, and expressed. There are things which are not only 'not done' but which are even 'not thought'. In a tribe of warriors for instance, whose members live by killing and robbing members of other tribes, there might be an individual who feels revulsion against killings and robbing. Yet it is most unlikely that he will be aware of this feeling, since it would be incompatible with the feeling of the whole tribe; to be aware of this incompatible feeling would mean the danger of feeling completely isolated and ostracised. Hence an individual with such a feeling of revulsion would probably develop a psychosomatic symptom of vomiting, instead of letting the feeling of revulsion penetrate to his awareness." Further certain words taken on charged and special meaning for a group. For example, the word federalism is anathema for some Sinhalese, meaning a separate state for the Tamils. Just mention of the word is enough to arouse strong emotions. The constricting effect of one exclusive language also explains why learning other languages expand consciousness to become aware of other realities, opening windows into other worlds.

Thus, if we belong to a particular culture or social group, it will influence our perception (awareness) of the world in subtle and unconscious ways. More than language, it is the concepts, attitudes the general cultural milieu and peer group pressure that shapes the perception of the members of any group. Sheriff and Asch have shown by simple experiments the effects of peer group pressure on perception. They found that when subjects are placed in groups, their judgements began to converge towards a group norm, or conformed to majority opinion even where obviously erroneous. The process of defining and interpreting (constructing) situations by relying on one another underlies the formation of social norms in society-consensus agreement about how to perceive situations and appropriate ways to behave in such situations(Atkinson, 1987).

In this connection it is appropriate to describe the social phenomena called 'deindividuation' observed in crowd behaviour where individuals experience a feeling that they have lost personal identities and merge anonymously into the group. Thus, when crowds are made to focus on external events and led to states of high emotional arousal, it readily produces reduced self-awareness leading to diminished restraints against impulsive behaviour, diffusion of individual responsibility, feeling of righteous indignation, power, belonging and other cognitive and emotional conditions associated with unruly mob behaviour(Atkinson, 1987). A classic example of this type of herd behaviour was the 1983 July riots in the south of Sri Lanka where large number of people took to the streets in an atmosphere of high emotional arousal, to indulge in an orgy of violence and destruction, that as individuals or under other circumstances they would never have dreamed of committing. Individuals thus find themselves behaving in ways that are inconsistent with their held belief, creating cognitive dissonance. They then reduce their discomfort by rationalising (i.e. the Tamils deserved it or they had to be taught a lesson because), re-interpreting events or changing their belief to fit their actions (Festinger, 1959).

Social comparison takes place only between groups of equal status or with itself at an earlier time. It is important to note that even in the pre-independence era the 'reference group' for the Sinhalese and Tamils was each other and not the British, who were regarded as a dominant, superior group with a positive social identity and thus not comparable. Even today, the Tamils are not willing to accept an inferior status vis-à-vis Sinhalese in Sri Lanka but are able to adapt to a lower and 'servile' position in the many foreign countries they have migrated to.

If anger and aggression are to result from the perceived inequity, then the disadvantaged group must not attribute the disadvantage to themselves, must not take responsibility for the inequity. But they may not attribute the cause to the truly responsible group (e.g. the British, the ruling elite) or socio-economic conditions. Anger and violence can be displaced from real sources or problems to more available and vulnerable targets such as a convenient scapegoat. Thus, we saw the frustration resulting from real socio-economic problems of poverty, unemployment, unequal distribution of wealth found in Sri Lanka displaced on to the Tamils (e.g. 1958-1983).

The Sinhalese and Tamils have gone through a cycle of perceived inequity during this century. In the beginning the Tamils were perceived as holding an unfair advantage with a position inconsistent with their numbers in regard to education, jobs and business.

Table 1 Decline in the privileged position of Tamils
(from Schwarz, 1988)

	1956	1965	1970
		(Percentages)	
Ceylon Administrative Service	30	20	05
Clerical Service (incl. postal, railway, hospital and customs)	50	30	05
Professions (engineers, doctors, lecturers)	60	30	10
Armed Forces	40	20	01
Labour Forces	40	20	05

Also see Chapter 1 Table I. Employment of Tamil Minorities

This led to periodic anti-Tamil violence and affirmative action by successive government. In time this overshot the mark and Tamils perceived themselves disadvantaged in terms of costs (repeated violence, destruction of property, discrimination etc.) compared to investment (education, citizenship, ethnic proportion etc.) and felt themselves slipping from the privileged position they had enjoyed in certain key areas (see Table l) to become '2nd class citizens' (Schwarz, 1988). This led in turn to increasing defiance and militancy among Tamils ending in the struggle for separation. It is worth noting that through all this, the (Indian) Hill Country Tamils, who were the most deprived, did not react till recently due to their negative social identity, acceptance of domination by other groups, and lack of reference group for comparison. The 'concept of deservedness' is very important in perceived injustice(Brown, 1986). It is easy to see how elevation of social identity is a potentially revolutionary act (by changing comparison groups and perception of justice) as is happening in the Hill Country today. According to Brown (1986), a disadvantaged group works to elevate group identity chiefly by making propaganda in favour of group appearance, language and abilities as was seen in the Sinhala-Buddhist and Tamil-Hindu revival of the late 19th and early 20th century.

Ethnic groups like the Sinhalese and Tamils perceive external events quite differently and this can lead to perceived injustices, polarisation and hostility. An innocuous or neutral act perceived as aggressive and threatening, elicits a hostile response which in turn causes an aggressive reaction confirming the original perception. The reciprocal

interaction sets in motion a spiralling vicious cycle. The presence of mass media that consistently feed misinformation, accentuates and aggravate these different views and the absence of meaningful contact, communication and information about how the other is thinking and feeling, in short the ability to understand the other's point of view or empathy(Allport, 1958), is the root cause of this polarisation. This narrow one-sided framework, creates a rigid and tainted perspective which is the cause of ethnic or nationalistic hostilities and conflicts.

The general prescription from social psychologists for resolving inter-group conflict, is equal status contact in the co-operative pursuit of a common goal (Brown, 1986). This can be easily done by the State planning ventures like the integrated economic development of the country or more specific projects like the Mahaveli Development where the different groups are given equal opportunity in various aspects of planning and employment as well as being made to feel part of the team, having a stake in the eventual result. That this has not been possible despite the egalitarian rhetoric (Accelerated Mahaveli Programme in actual practice) underlies the discriminatory functioning of the State and difficulties of changing basic positions and perceptions. A good beginning may be to make available unbiased information to break down the barriers to misperception. An effort has to be made to become aware of other points of view, to graduate from the narrow 'frog in the well' perspective to a more broader outlook. It is interesting that both Buddhism and Hinduism emphasise correct perception as a means of liberation. Buddha called it right understanding or awareness, while Hindu scriptures describe it as expansion of consciousness. The essence of their teaching is to change from the mundane way of seeing to enlightenment, a completely revolutionary perception of the world and self. What they call liberation is to break free from the narrow and parochial, psycho-social determinants of how we perceive and think. We have to go beyond the superficial differences that divide us, to see the essential unity of all humanity.

Aggression

Group or ethnic identity is characterised by a particular way of perceiving and responding to the world. Perceived threat to the group identity, injustice or inequity in comparison to reference groups usually elicits anger, hostility and aggression (Brown, 1986; Atkinson, 1987). When a group indulges in aggression against another group it is called war. As noted earlier, man is the only species that indulges in war-that is large scale killings, torture and destruction of its own species.

According to the ethnologist Lorenz, man shares with other animals an innate mechanism for aggression, which has served a variety of adaptive functions for the survival of the species during its evolutionary history(Lorenz,1963). Animals rarely kill members of other species except in the relationship of predator to prey and that is limited to what is needed for food. Aggression within the species is restricted to certain well recognised conditions and rarely, if ever, end in death. "It occurs only when population numbers have overtaken the resources of the environment so that serious overcrowding is brought about" (Mathews, 1964).

Although aggression has an adaptive function, rarely did such fighting within the species ever lead to dangerous physical contact or in death, for that would have worked against the survival of the species. Nature through natural selection has evolved a highly complex behaviour pattern, minutely ritualised into display, threat and submission or appeasement, so that fights are generally no more than trials of strength, followed by disengagement and rapid withdrawal by the weaker. These ritualised appeasement or submission gestures to signal surrender such as the dog rolling over to expose its vulnerable neck, sets off inbuilt automatic mechanism inhibiting killing and injuring fellow members of the species.

Lorenz(1963) describes the adaptive function of this limited intra-species aggression, which man shares with other animals, as spacing out of individuals, selection of better genes, and establishment of a social rank order. The establishment of a dominant hierarchy reduces inter-group quarrelling, provides stability and structure, and facilitates efficient decision making. The spacing of the individuals within a habitat would ensure an even distribution of resources. In animals that function in social groups, territoriality or the defense of a fixed, geographically demarcated area against intrusion by other members of the species serves an adaptive function by enhancing differential survival and reproduction(Boelkins, 1970). In The Territorial Imperative, Robert Ardrey (1967) attributes most of man's ill to his drive to conquer and maintain a geographical territory.

The problems of territoriality is at the centre of the Sinhala-Tamil ethnic conflict. The Sinhalese consider the whole of Sri Lanka as their home territory-Sinhaladipa, and hence have a right to colonise and settle in any part of it. They strongly feel that the other ethnic groups inhabiting the island are migrants whose home territory is elsewhere. The 'bhumaputira' theory holds that they are the legitimate 'sons of the soil' and have all rights procuring from it. The Tamils on the other hand, also regard themselves as heirs to the land, a well demarcated but restricted area-the North and the East of the island and claim to have been living in their homeland from historic times. The separatist

demand for a state of Tamil Eelam is based on this very concept of home territory (see Chapter 1 & 2). In fact one militant group, the EROS, also include the hill country-Malainadu-as part of the Tamil territory as it has been settled and developed by 'Indian' Tamils. There is further disagreement as to whether the North and East is to be merged and whether the Muslims have a right to a territory of their own. Even India's intervention can be seen as a defense of her 'geopolitical' territory-India now expanding her territory to include the whole of South Asia (as Nehru (1991) once dreamed of) and taking action to maintain her permanent position and security in the region.

This fundamental dispute over territoriality, evoking as it does the baser instincts and strong emotions of those concerned, is the crux of the ethnic conflict and can be taken to show that man is after all a territorial animal.

A concept similar to that of territoriality is that of personal space. There is believed to be a hypothetical sphere around each individual, a kind of portable territory, within which the individual will not tolerate another to enter. Repeated violation of this personal sanctity as in over-crowding can lead to aggression.

It is quite possible that high population densities cause socio-economic deprivation in terms of poverty, unfulfilled aspirations, frustrations and unemployment which in turn are responsible for aggression. As discussed in chapter 1, the rapid growth in population in Sri Lanka since 1946 has meant high population density coupled to dwindling resources resulting in socio-economic deprivation for large sections of the population. The large population faced with lack of cultivable land or other opportunities have led to overcrowding in urban slums. The increasing differences between the poor and affluent, exposure to a quality of life that remain unreachable, and unemployment, particularly among the educated youth, has generated considerable discontent, anger, hostility and aggression that have manifested in such social pathological indices as high suicide and homicide rates. However instead of focusing on these fundamental socio-economic and population problems, successive generations of politicians have turned the discontent against convenient scapegoats like the Tamils. The opportunistic manipulation of ethnic emotions has been an important cause for periodic mob violence against Tamils in Sri Lanka since 1958 and an easy platform to win elections. The ethnic war from 1983 could be understood as a direct consequence of the population explosion, the numbers having become too large to be supported by the limited resources of this small Island.

Thus, it's clear that under natural ecological conditions intra-species aggression is seen in defense of territory or as nature's solution for overpopulation. However, in the animal

world, aggression rarely ends in actual death, there being some inborn inhibition to killing. It is pertinent to ask why such inhibitions do not operate in man, virtually the only species with a history replete with genocidal behaviour, the only 'unhinged killer'.

Man, thanks to his cerebral dominance, has gradually eliminated the natural selection pressure reducing death rates and prolonging life for all members of the species. Western medicine has conquered disease, technology the problem of food, shelter, temperature and other natural forces. Man is no longer subject to environmental evolution, though he has created potential dangers-over-population, ecological disequilibrium, pollution, and threat of nuclear holocaust. Thus, some argue that though still left with his older instinctual drives and tendencies like aggression, man has not been able to evolve socio-culturally (civilised ways of solving problems) to keep pace with his technological progress. Modern powerful and efficient weapons have made it possible for killing to take place at a distance or even by remote control so that the killer doesn't directly experience the consequences of his actions, which would normally have activated inhibitory mechanisms(Lorenz, 1963; Andreski, 1964).

It is significant that much of the war in Sri Lanka is fought with modern weaponry that operate at a distance-machine guns, land mines, artillery and gun boat shelling, airplane and helicopter bombing and more recently rockets and missiles. The combatants are rarely in direct vision, most casualties are civilian, while the political leadership and military hierarchy that makes the decisions about fighting are far removed from the firing line. But it was equally true that there were several incidents during the racial riots and the war itself of direct slaughter of civilians, men, women and children by swords and other weaponry. This kind of 'unhinged killing' appears to take place wherever there is human warfare usually as a reactive rage. It took place with the Indian army, Rwanda, Bosnia and also happened with the US army in Vietnam, for example at May Lai. Though territorialism and excessive population may explain aggression and war on an ecological basis, we have to go deeper into the human psyche to look for the causes for all that humans do.

Freud (1961) saw aggression as a basic instinct to destroy and kill that cannot be suppressed but builds up till discharged. Civilisation's attempts to inhibit man's aggressive drive results in outbreaks of war from time to time. Later psychoanalysts do not accept aggression as a primary drive but rather see aggression as only one other way that instinctual aims are striven for in response to obstruction or frustration(Solomon, 1970). The periodic mob violence against the Tamils can be seen as a result of the socio-economic frustration of the urban slum dwellers displaced on to a convenient scapegoat. The

reprisal killings of civilians by the army when one of their colleagues was killed largely followed frustration of not finding the elusive guerrillas who were responsible. The frustration of Tamil youth when they found their further progress obstructed at the University entrance due to discriminatory restrictions (standardisation) by the state was the beginning of the Tamil militant movement.

Studies have shown that aggression can occur as a response to pain and as a response to threat to status(Boelkins, 1970). Pain is the most consistently reliable single cause of aggression. Animals with complex brains readily learn when an event is a threat of pain, and they will respond as aggressively to the perceived threat. Psychological pain and threat (such as the loss of identity) may represent analogues to physical pain. Similarly, a threat to status already held is commonly responded to with aggression. The whole Tamil militant response can be seen as a response to the pain of repeated ethnic violence and the attempt to demote minority Tamils to a second-class status, within Sri Lanka.

The Neo-Freudian humanist, Erich Fromm (1973) distinguished two different kinds of aggression in man :

"The first, which he shares with all animals, is a physiologically programmed (reaction to) threats. This defensive, 'benign' aggression is in the service of the survival of the individual and the species, is biologically adaptive, and ceases when the threat has ceased to exist. The other type, 'malignant' aggression, i.e. cruelty and destructiveness, is specific to the human species. It is this malignant aggression that makes man the only primate that kills and tortures members of his own species without any reason, either biological or economic, and who feels satisfaction in doing so".

From, as part of malignant aggression, further delineates two character-rooted passions:

1. Sadism-The passion for unrestricted power over another sentient being
2. Necrophilia-The passion to destroy life and the attraction to all that is dead, decaying and purely mechanical.

The two forms of aggression gives us one way of looking at the violence that has erupted in the Tamil society. As already described in chapters 1 & 2, the Tamil society was a remarkably non-violent society until the late 1970's, where a murder was such a rarity as to create a sensation for months on end. The Tamil political protest to increasing state discrimination and repression from 1956 had taken a non-violent form. Despite what the late Bishop Wickramasinghe called 'recurrent mob violence' against the Tamils in the South from 1958, hardly a Sinhalese civilian was touched in the North up to 1984. The Sinhalese, felt safe in Tamil areas, until evacuated by the security forces in the

aftermath of the '83 ethnic holocaust. It is indeed a radical transformation for a society from the earlier peaceful state to the hostile, aggressive state of today.

Initially the violence was a form of defensive aggression against a threat to the Tamil community. Devaluation of its language meant a threat to its identity, state sponsored colonisation was perceived as invasion of its territory, socio-economic deprivation threatened its very survival and political discrimination meant degradation to second class citizenship. Recurrent mob violence against persons and property and increasing violent repression by the state provoked the youth to take up arms as a form of reactive aggression. Initially, this liberation struggle won the respect and support of the international community.

But more recently the violence has taken a more virulent and malignant form exemplified by glorification of mechanical weapons more than life, fanatic intolerance to any forms of opposition or difference of view, internecine fratricide, spate of political and extra-judicial killings, fascist and totalitarian rule, massacre of man, women and children, desecration of dead bodies, and public exhibition of parts of bodies (necrophilia), torture and acting as mercenaries in foreign countries (e.g. Maldives). The rapid change from defensive aggression to what Fromm (1973) called malignant aggression makes one wonder whether the distinction can be held, or rather it seems that one sort of violence leads to the other, at least in humans.

Some clinical studies that may have some relevance to the different types of violence noted between the Sinhala and Tamil communities (see Chapter 2) are discussed by Tobias and Neziroglu (1981):

"Megargee (1960) has made distinctions between habitually aggressive individuals who are under-controlled, and those who commit crimes of extreme violence but who have no previous history of assaultive behaviour and are over-controlled. The under-controlled type is impulsive and usually responds to frustration through aggression. The over-controlled type rarely responds with aggression because of strong generalised inhibitions. Therefore, he aggresses only when the instigation has built over time."

Relatively, the Tamil society is characterised by more conservatism, control and inhibition than the Sinhalese. The Tamil militant violence can be understood as stemming from repeated provocation that has built up over time. It has been more calculated, planned, focused on specific targets and 'cold blooded'. Generally the Sinhalese mobs and even the army have shown reactive rage to some immediate events-impulsive, unplanned and transient ('hot blooded').

According to Social Learning Theory aggression is learned through observation or imitation, and the more often it is reinforced, the more likely it is to occur. By a series of ingenious laboratory experiments Prof. Bandura (1973) established that children will learn and imitate adult models of physical aggression. Models who are of high status, influential and who are rewarded for their aggressive behaviour will be imitated preferentially by children. From observing the behaviour of others, one can learn general strategies that provide guides for actions which go well beyond the specific modelled examples. Thus, an aggressive style of coping with problems can generalise to large number of situations through observing just one such successful modelling. Exposure to modelled aggression can affect not only observers' actions but also their attitudes and values. Children will adopt the behaviour of a successful aggressor and hold him in high regard even though it may initially go against their value system. Children do not necessarily learn only what is overt and consciously taught by adults but can pickup unconscious, covert and subtle messages through non-verbal and other clues. Thus, it is quite possible that children growing up in the increasingly politically repressed Tamil society since 1958, easily learned the inner resentment, hostility and aggression of the outwardly passive elders. Sometimes children are made to act out the hidden wishes of their parents. Of course, once the militant struggle broke out, successful young models were plenty and reinforced by propaganda, social approval and admiration.

One of the most powerful sources for observational learning is modern mass media, particularly the television and video films. Mass media presentation are believed to be authentic and credible, giving an impression that the world is really the way it appears on these representations-blurring the distinction between reality and fantasy. The media teaches that the world is a violent and untrustworthy place and demonstrates for them a violent technique for coping with the putatively hostile environment (Ilfeld, 1970).

The Tamil militant leader Prabhakaran is reported to have said that he got most of his 'ideas' from viewing Clint Eastwood and other thrillers (Weaver, 1988). Militants resting in camps spend a considerable part of their leisure hours watching the various thrillers on video. There can be no doubt that the spate of video thrillers flooding the market in the last few years have popularised violence among the present generation of Tamil youth. In addition, radical Marxist and socialistic ideology, Che Guevera and Subash Chandra Bose models, and the examples of nationalistic and ethnic conflicts that was seen elsewhere in the modern world were the ingredients for the birth of a liberation struggle against a violent system.

Historically war has been a male preoccupation. Females have usually played a more

peaceful, caring, nurturant and protective role. Males are biologically more aggressive than females. Even as children, boys tend to be more aggressive, indulging in more 'rough and tumble play,' preferring rigorous activity. This may be due to differential effect of sex hormones, and partly due to the different ways the sexes are brought up, social expectancies and the role models they imitate. Studies have shown that though males spontaneously perform more imitative aggression than girls, girls were able to perform aggressive acts when they were given incentives to do so. Thus, it would appear that social sanction for females to behave aggressively can bring out aggressive acts they had learned as was seen in quite competent female wings of the militants. Although it is generally accepted that certain human tribes have special martial abilities (among the Indians, the Gurukhas, Sikhs and Rajputs are famed for their fighting prowess), this may as well be a subcultural influence, depending on how the males are brought up in the community. While the Tamils, a relatively peaceful society, have shown remarkable fighting spirit when provoked, even standing up to the aforementioned. Thus, it is clear that aggression and violence can be learned when the need arises.

When threatened with loss of status or identity a group will usually try non-violent alternatives before resorting to violence. The Tamils had tried the parliamentary democratic system and then protested non-violently using satyagraha, sit-ins, petitions etc. with apparent failure (indeed there was increasing state violence and repression) before turning to violence.

Violence may seem to be the most direct means of getting the job done and the means involving the least danger of compromise, or when an outside force is perceived to be threatening the annihilation of a group, violence may seem to be the only means to achieve the important goal. Violence often appears to promise favourable short-term results and it readily discharges frustration that may have built up due to political repression. In the absence of sufficient group cohesiveness to sustain other 'slower' options, violence requires much less discipline and is easily understood and adopted. Violence increases group cohesiveness by pushing people into opposing groups, each of whom sees the other as an enemy. The perception then of an increasing threat to group survival facilities intergroup cohesion and solidarity.

Violence is a signal from an oppressed group so drastic that it cannot fail to be perceived by those in power who previously had been inattentive to other forms of communication and who had not been conspicuously sensitive to social ills. Thus, incidence of violence serves as a barometer of the degree of frustration prevalent in a society (Ilfeld, 1970).

A state facing collective violence can either recognise the danger signal and open

communication and negotiations to redress grievances and social inequalities, or reduce discontent by correcting such factors as violation of human rights, economic deprivation, dashed hopes or it can take an increasingly intransigent stand (6th Amendment), fight to maintain the status quo and increase its own hostility and repression leading to a vicious cycle. It can do this by institutionalising violence-passing draconian and repressive laws, such as the Emergency Regulations and PTA in Sri Lanka, which gave wide powers to the security forces. By closing the normal channels of communication and redress, and by bypassing the normal due process of law, abuse of power such as arbitrary detention, disappearances, deaths and torture become common place and state terrorism is established. This is turn increases the violent reaction of the repressed group, confirming the necessity for more counter violence. More individuals become convinced of the need for violence and a vicious cycle is built up with a self-fulfilling effect. If unrestrained, collective violence can yield human misery of a magnitude unimaginable with other non-violent options. The degree of suffering in terms of deaths, physical and psychological trauma, destruction and disruption for the Tamil and the Sinhala society is only too clear now.

And yet the conflict remains unresolved, the spirit of national reconciliation is yet to be manifested. For whatever the final political settlement may be, the two ethnic groups have to live side by side on this small island. The tragedy is that alternative methods besides violence could have achieved the same or better goals (see Chapter 8). Finally, learning theory indicates that as violent behaviours are practised, they become learned, particularly by growing children, to be increasingly relied upon in subsequent encounters. The most unfortunate repercussion of collective violence is the continuation of the violent process itself. One must distinguish the destructive long-term effects of violence-repression, fear, mistrust and brutalization of the practitioner, from the short-term results of violence-which often appears favourable (Ilfeld, 1970).

Perhaps the most tragic long term consequence of violence is the development of a cult of violence. Violence becomes institutionalised within the state and society itself. It becomes a way of life. Part of this system is the aggression training function used for war. This is a most remarkable function as Professor Bandura (1973) points out, for the system can within a relatively short period, transform people who have been taught to deplore killing as morally reprehensible into skilled combatants who feel very little compunction or worse still, even a sense of pride, in taking human life.

"This is accomplished through indoctrination that assigns a high moral purpose to warfare. The force of the moral appeal is strengthened by portraying the enemy as servile

fanatics or subhumans driven by ruthless leaders .... People selected as targets are ... often dehumanised ... by being viewed not as individuals with sensitivities, feelings and hopes, but as stereotyped objects bearing demeaning labels", e.g. terrorists, traitors, subversives, dogs etc.

The military-militant training is a closely regulated process whereby the new recruits are completely brainwashed into accepting a new way of life. Every aspect of their life is brought under control while their old ties are completely eliminated. They are strongly disciplined and made into obedient automatons, willing to take orders without questioning. Desensitisation to killing fellow human beings is accomplished through the above mentioned indoctrination and practical initiation: *"Once a man has killed a couple of times, his reluctance to do so again wanes: he can even become an addictive killer. And this can in addition become infectious."* (Tinbergen, 1981)

Stanley Milgram (1974) demonstrated by a series of ingenious experiments how orders from authority figures can make ordinary people carry out inhuman aggressive actions against helpless victims. The social psychologist from Havard, Roger Brown (1986) argues that institutionalised authoritarian systems need not only have rigid, sado-masochistic, ethnocentric and prejudiced individuals but also clever propagandists, clear thinking ministers, sensitive diplomats and courageous military men. Many studies of Nazi officers who actually carried out the orders for mass killings found they were actually ordinary human beings (Arendt, 1963). In view of its wide prevalence in Sri Lanka, particularly among the Tamils, it may be worthwhile describing the authoritarian personality which refers generally to the majority of ordinary citizens who are part of an authoritarian system where they readily accept and carry out orders from above while being autocratic and domineering with those below in the hierarchy.

An authoritarian (or prejudiced) personality is characterised by rigidity in thinking, failure to see all relevant sides of the problem, dogmatism, a narrowing and constriction of the cognitive process, low self-awareness while showing marked intolerance of other views. They think in clear and definite categorical terms, dichotomising the world into good and evil, right and wrong for example, accentuating the distinction between their group and other groups. The authoritarian personality has an unrealistically high opinion of himself and his ethnic group (ethnocentrism), though repressed from consciousness are his own unacceptable impulses of sex, aggression, animosity and other negative characteristics. They unconsciously project these repressed, negative qualities onto other groups. They externalise conflict and are extrapunitive. Ever ready to blame others, they hold rigidly moralistic views and their judgements are often harsh, requiring severe or

violent punishment for minor transgression. A deep insecurity lies at the root of the authoritarian personality as a result of which he is extremely distrustful, and paranoid. The authoritarian personality needs order, especially social order, where there is a definite hierarchy and power arrangements are clear(Allport, 1958; Brown, 1986). He likes authority, discipline and admires leaders who exercised power and control over others (Napoleon Bismarck, Hitler); whereas the tolerant personality admires artists, humanitarians and scientists (Frenkel-Brunswik, 1945). The preference for an orderly authoritarian and powerful society is marked by extreme patriotism, nationalism and a desire for a strong leader. Authoritarian patterns become set at an early age, specially if the child rearing practices and educational system present the parent, teacher and social leaders as authority figures to whom submission is necessary (Frenkel-Brunswik, 1945; Kutner, 1950). In considering obedience to authority and authoritarian personalities, it is important to stress that most individuals in the society belong to the bottom of hierarchy. Nevertheless, they are basically *"Power oriented in their personal relationships-submissive and obedient to those they consider their superiors, but contemptible and authoritarian towards those considered inferior"*(Atkinson, 1987). Both Adler and Nietzche described the 'Will to Power' as a basic human trait. What is evident is that there is a will to power manifesting itself in extreme form in a few leaders as an intense struggle to dominate and rule, using all the means available, eliminating all obstacles in their path. Sinhala and Tamil Nationalism has served a few to attain power but spelt real misery and suffering for the ordinary people.

For a solution to misery and suffering caused by the ethnic violence and aggression in general, we may have to finally turn to the spiritual teachings of Buddhism and Hinduism... According to Hindu Psychology, aggression is typical of the 'Rajas' personality. Sages like Gandhi, Aurobindo and Krishna in the Gita always insisted that active resistance is to be preferred to 'Tamas' which is characterised by inertia and passivity. A Tamas personality will uncomplainingly accept injustices and repression. Thus, the righteous wrath of the Khastriya or warrior, to pull the too compliant and submissive from their Tamasic torpor, to right the wrong and re-establish justice, to do their duty (Dharma) is always the better pursuit.

A convincing argument, popular among Tamil youth at the beginning of the struggle, for using violence was that the Tamils as a group had become passive and submissive, unable to resist the oppression against them. They needed the Rajasic stimulus and activation to bring them out of the Tamasic torpor or servility and self-interest, to introduce altruism, nationalism, sacrifice and activism. And this the violence has achieved

to some extent, forcing some to make a choice, to avoid becoming passive victims of the increasing violence and counter-violence. But many have simply fled.

Nevertheless, in the Hindu system, the pride of place is given to the sattvic principle-equilibrium, peace, tranquillity, as this frame of mind is conducive to the highest path, to finally transcend the Gunnas and achieve true liberation. Both Buddhism and Hinduism stress Ahimsa as a sine qua non for the spiritual path. For violence invariably destroys the practitioner, dehumanising him in the process, and brings disequilibrium, vicious karma, samskara and vasanas (impressions) on the mind and physical tumult in its wake (see case history of torturer in chapter 5). By creating an atmosphere of hostility and violent conflict, a cult of violence comes into being. Children growing up in such an environment imbibe these aggressive coping strategies and they themselves then attempt to solve their problems by violent methods, setting in motion a vicious cycle.

Ahimsa on the other hand, that is non-violence in thought, word and deed towards all creatures, harmonises the individual with the environment and brings a peace that passeth understanding called Shanti. It is hoped to put forward the viability of non-violent methods for the readers consideration in the last chapter.

REFERENCES

1. Allport, G.W. (1950). The Role of Expectancy in War. Basic Books, USA.
2. Allport, G.W. (1958). The Nature of prejudice. Anchor Books, USA.
3. Andreski, S. (1964). Origins of War. in The Natural History of Aggression, ed.Carthy, J.D. & Ebling, F.J., Academic Press, London.
4. Ardrey, R. (1967). The Territorial Imperative. Atheneum, New York.
5. Arendt, H. (1963). Eichmann in Jerusalem: a report on the Banality of Evil. Viking Press, New York,
6. Argyle, M. (1969). Social Interaction, Tavistock publications, London
7. Atkinson, R.L., Atkinson, R.C., & Hilgard, E.R. (1983, 1987). Introduction to Psychology. Harcourt Brace Jovanovich Publishers, San Diego, USA.
8. Arasaratnam, S. (1970). Nationalism in Sri Lanka. In Collective Identities, Nationalism and Protest in Modern Sri Lanka. Eds. Robert, M., Marga, Colombo.

9. Bandura, A. (1973). Aggression: A Social Learning Analysis. Prentice Hall, New Jersey, USA.

10. Bittker, T.E. (1970). The Choice of Collective Violence in Intergroup Conflict. in Violence and the Struggle for Existence, Little Brown & Co., Boston.

11. Boelkins, R.C. (1970). Biological Basis of Aggression, in Violence and the Struggle for Existence. Little Brown & Co., Boston.

12. Brown, R. (1965, 1986). Social Psychology. (1st & 2nd ed.), Macmillen co., New York.

13. Daniels, D.N., Marshall, F.G. & Ochberg, F.M.(Eds.) (1970). Violence and the Struggle for Existence. Little Brown & Co., Boston, USA.

14. Erikson, E.H. (1968). Identity, Youth and Crisis. Faber & Faber, London. See also Erikson (1963). Childhood and Society. Norten & CC.IN.Y.

15. Fanon, F. (1967). Toward the African Revolution. Groove, New York.

16. Festinger, L. & Carlsmith, J.M. (1959). Cognitive Consequences of Forced Compliance. Journal of Abnormal and Social psychology, 58:203-210.

17. Frenkel-Brunswik, E. & Sanford, R.N. (1945). Some Personality Factors in Anti-Sementism, Journal of Psychology, 20:271-91.

18. Freud, S. (1961). Civilization and its Discontent. Trans. & ed by Traciiey, S., W.W.Norton & Co., New York.

19. Fromm, E. (1960) Psychoanalysis and Zen Buddhism. Unwin, London.

20. Fromm, E. (1973) The Anatomy of Human Destructiveness. Penguin Books, Middlesex, England.

21. Geiger, W. (1950). Mahavamsa-translation, Pali Text Society, Luzac & Co. Ltd., London.

22. Ilfeld, F.W. & Metzner, R.J. (1970). Alternatives to Violence, in Violence and Struggle for Existence, Op.cit.

23. Jayawardena, K. (1986). Ethnic and Class Conflicts in Sri Lanka. Centre for Social Analysis, Dehiwala, Sri Lanka.

24. James, W. (1890). The Psychology, Holt, New York.

25. Kutner, J.B. (1950). Patterns of Mental Functioning Associated with Prejudice in Children, (unpublished), Harvard College Library, Cambridge. Quoted by Allport (1958).

26. Mathew, H.L. (1964). Overt Fighting in Mammals. in The Natural History of Aggression, ed.Carthy, J.D. & Ebling, F.J. Academic Press, London.

27. Milgram, S. (1974). Obedience to Authority. Harper & Row, New York.

28. Nehru, J. (1991). The Discovery of India. Oxford University Press, New Delhi.

29. Reddiar, K.A. (1997). Shout and Plea from Trincomalee. Tamil Times, 14:5, 22-23.

30. Schwarz, W. (1988). The Tamils of Sri Lanka. The Minority Rights Group, Report No.25, London.

31. Senanayke, D.S. (1939). Ceylon Daily News of 17 April, 1939. Quoted by Jayawawardena (1986).

32. Sinha, H. & Page, R. (1971). Current Stereotypes: A little fading, a little faking. Journal of Personality and Social Psychology, 18, 247-55. Quoted by Brown (1965).

33. Siriwardene, R. (1984). National Identity in Sri Lanka: Problems in Communication and Education in Sri Lanka: The Ethnic Conflict. Committee for Rational Development, Navrang, New Delhi.

34. Solomon, G.F. (1970). Pychodynamic Aspects of Aggression, Hostility and Violence, in Violence and Struggle for Existence, Op.cit.

35. Taijel, H. (1978). The Social Psychology of Minorities. The Minority Group Report No.38. London.

36. Tabias, J.A.Y. & Neziroglu, F.A. (1981). Aggressive Behaviour, Clinical Interfaces, in Aggression and Violence: A Psycobiological and Clinical Approaches. Edizion, St. Vincent, Italy.

37. Tinbergen, N. (1981). On The History of War, in Aggression and Violence: A Psychoogical and Clinical Approach, Edizion, St. Vincent, Italy.

38. Weaver, M. (1988). A Reporter at Large. The New Yorker, March, 21, 1988, New York.

CHAPTER 4

THE PSYCHOLOGICAL EFFECTS OF WAR

Introduction

The psychological costs of war for both the civilian population and the combatants are only now becoming understood. Only in recent times have the psychological reactions to severe stress, such as in disasters including the man made disaster-war, been recognised and studied. One outcome has been the development and acceptance of the concept of Post Traumatic Stress Disorder (PTSD) and its inclusion in the American Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III) (American Psychiatric Association (APA),1980) and the World Health Organization's, International Classification of Diseases, 10th Revision (ICD-10) (WHO,1992), classifications as a mental disorder. Trauma here refers to psychological trauma due to severe stress or catastrophic experience. Psychodynamically war is a form of severe and prolonged environmental stress.

Psychological reactions to war were diagnosed as neurasthenia in the American Civil War. Out of this war too arose the observations of Da Costa on the Irritable Heart Syndrome (Trimble,1981). During World War I, traumatic reactions to combat were called "shell shock" by the British Pathologist, Colonel Fredrick Mott, who regarded such reactions as organic conditions produced by minute haemorrhages of the brain (Scott,1919). It was only gradually realized, however, that only a very small percentage of such cases represented actual physical injury from the concussion of exploding shells or bombs. Not only were similar symptoms noted in men not exposed to exploding shells, but also such symptoms were seen to recede when the affected individuals were removed from the danger area of fighting or when various psychological treatments were employed (Trimble,1981). Most of these cases were suffering instead from the general war situation with its physical fatigue, the ever present threat of death or mutilation, and severe psychological shocks. Southward (1919), in an analysis of 589 case histories of shell shock and other neuro-psychiatric disabilities seen in World War I, came to the

conclusion that they were essentially psychoneurosis. Meyers (1940) who had experience of over 2000 cases of shell shock felt 'psychical causes' were involved in the majority of cases, giving rise to either hysteria, neurasthenia or more grave instances of 'mental disorder' which were precipitated by horror and fright .

During World War II, traumatic reactions to combat passed through a number of classifications, such as 'operational fatigue' and 'war neurosis' before being termed 'combat exhaustion' or 'combat neurosis' in the Korean War and the Vietnam conflict. In World War II an estimated 10% of men in combat developed war neurosis (Coleman,1975). Common systems were dejection, weariness, tension, hypersensitivity, heightened startle reaction, sleep disturbances and tremors, more specifically anxiety, phobias & depression.

Kardiner and Spiegal (1941) developed the concept of post-traumatic neuroses as a 'common acquired disorder consequent on war stress' not dissimilar to responses to severe stress in peace-time. They defined traumatic neurosis, a breakdown in adaptive functioning, as a withdrawal of the organism from the stressful environment. The biological component of the disorder causes fundamental alteration in the autonomic nervous system. The resultant symptoms may correspond to any of the known mental disorders. However the actual character of the neurosis was thought to depend on several factors including the previous personality of the individual, the degree of stress to which he was exposed, his morale, the extent of incapacity at the time of the initial breakdown and the particular interpretation which the individual gave to the traumatic experience.

Studies carried out in situations approaching modern 'complete' war conditions which include invasion and occupation report considerable psychological sequelae. Death and destruction, life-threatening injuries, displacement, social chaos, separation, and loss are the grim realities of war, bringing devastation and human misery on unprecedented scales. The existing life-event schedules used to assess the degree of stress in civilian life pale into insignificance when applied to war stresses(Curran,1988). Studies of psychological consequences to Hiroshima or concentration camp survivors make abundantly clear the consequences of war. Thus, the 'survivor syndrome' consisting of a recognisable pattern of chronic anxiety, depression, social withdrawal, nightmares, sleep disturbances, somatic complaints; and often, fatigue, emotional lability, loss of initiative, and general personal, sexual and social maladaptation have been found in a large percentage of those who survived the Nazi concentration camps and Hiroshima(Raphael,1986). Lifton (1967) found Hiroshima survivors exhibiting the syndrome, "a pervasive tendency to sluggish despair....." They seemed to live a half life, as though they were 'walking corpses' or the living dead. In studies of concentration camp survivors, uniformly high percentages

such as 83%, have been found to suffer from this syndrome (Raphael,1986). Forty years after World War II, Australian veterans who had been Japanese prisoners of war, were found to have significant psychological sequelae. 71% had developed a post war clinical psychiatric disorder, namely Anxiety Disorders, Depression and Alcohol Dependence. In comparison, 46% of the combatants who served in the Asian and Pacific theatres were also found to have developed these disorders (Tennant et al,1986). Long Term, trans-generational effects on the children of Holocaust survivors and World War II combat veterans have been described (Coleman,1975;Rosenbeck,1988).

Since World War II, considerable research has been conducted on post-traumatic disorders, which frequently arise as a consequence of war. These wars are nowadays typically 'low-intensity' conflicts involving poor third world countries. It has been estimated that there have been over 150 such wars since 1945, where 90% of all casualties are civilians. According to Summerfield (1993), what predominates is the use of terror to exert social control, if necessary, by disrupting the fabric of grassroots social, economic and cultural relations. In contemporary conflicts, the primary target is often the population rather than territory, with psychological warfare serving as a central strategic element. Atrocities, including civilian massacres, reprisals, bombing, shelling, mass displacements, disappearances and torture is the norm. As can be expected, the consequences for mental health, not to mention the social, economic, cultural and other costs, can be substantial. Studies conducted in regions affected by civilian violence, riots, and civil war-such as Belfast (Northern Ireland), Kuala Lumpur (Malaysia), Cambodia, and Lebanon-have revealed significant levels of psychological morbidity among the affected populations (Curran,1988; Coleman,1975; Lyons,1971; Fraser,1971; Tan & Simons,1973; Nasr et al, 1971; Mollica et al, 198).

The variety of symptoms and mental disorders resembled those already reported. Prominent were psychosomatic complaints, fear, insomnia and other manifestations of anxiety and depression. Similar long-term psychological and social impairments-such as chronic anxiety, phobic symptoms, substance abuse (including alcohol and drugs), interpersonal difficulties (notably marital discord), chronic illness, and reduced occupational functioning-were observed in individuals who experienced, but were not physically injured in, the Birmingham Pub Bombing (Sims et al,1979). Studies focusing on particular groups caught in civil war such as children in Mozambique, Uganda, Chile, Philippines (UNESCO, 1949; Richman et al, 1988; Children's Rehabilitation Center(CRC), 1986; Cohn et al,1985) or torture victims from Latin American and African countries (Somner & Genefke, 1986) show long term neuropsychological consequences. The

Psychiatrist, Gerald Caplan(1971), working with returning veterans from the war in South East Asia, reported that a significant proportion suffered from depression, social alienation, anger and resentment, emotional irritability, poor control over aggression, alcoholism and drug addiction. More recent work by Horowitz (1985) and others with Vietnam war veterans and victims of disaster has developed the concept of Post-Traumatic Stress Disorder (PTSD). It is estimated that between 500,000 and 1.5 million of the Vietnam War veterans suffered from PTSD (Walker,1981). A study of Falkland War veterans reported 65% with PTSD (Orner,1988).

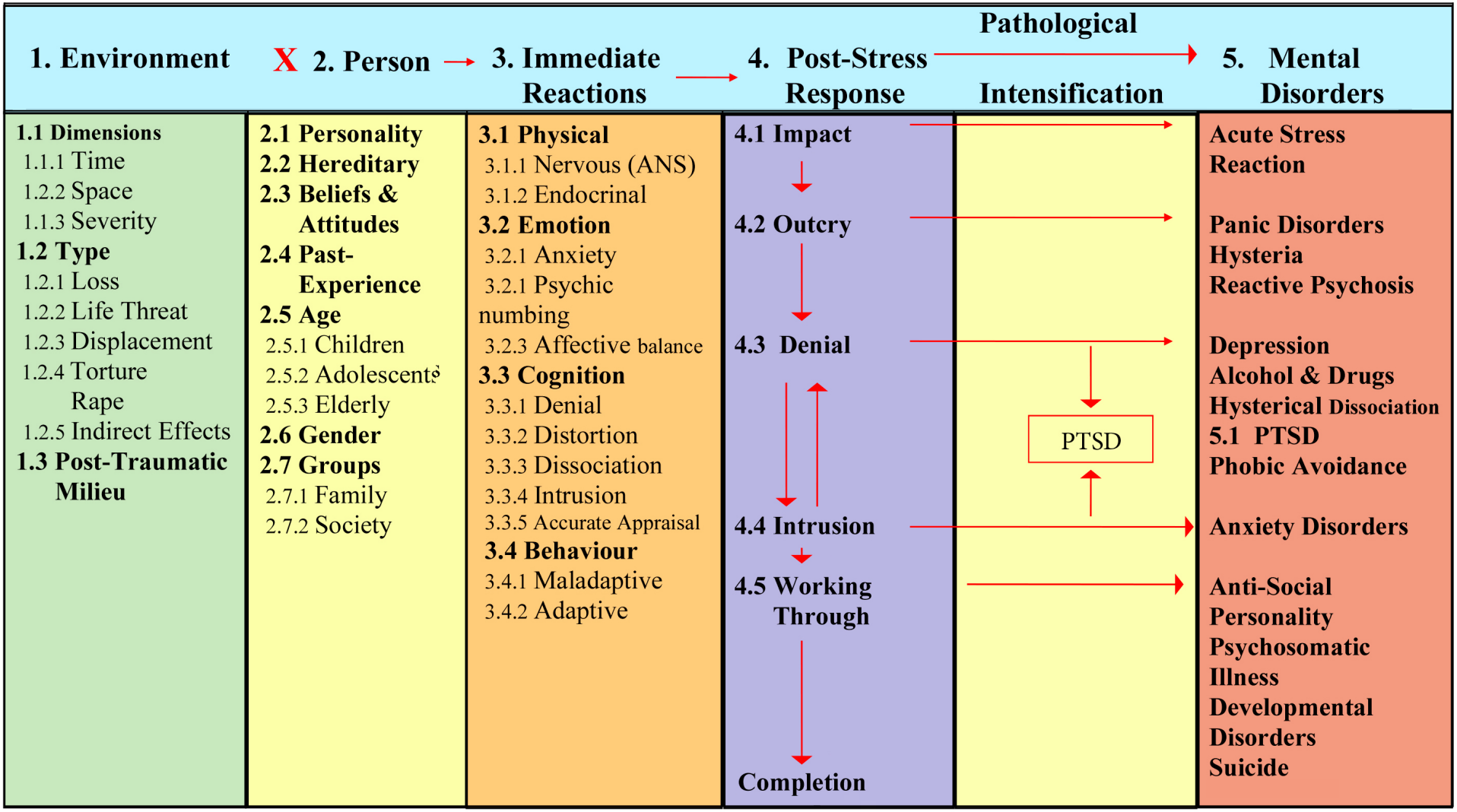
Recent surveys of populations exposed to severe environmental stress such as disasters have shown a high prevalence of psychological sequelae. Thus (Patrick & Patrick, 1981) found that following the cyclone which hit Eastern Sri Lanka, 77% of the directly affected population developed significant psychological dysfunction like anxiety (84%), phobia (68%) depression (41%) and disaster syndrome (23%). They identified early and delayed reactions and reported that only 15% had begun to lead a normal life at the end of one year. Significant prevalence of post-disaster psychiatric reactions to the Mount St. Helena volcanic eruptions were reported including depression, general anxiety and PTSD (Shore et al, 1986). Thus it has become increasingly clear that the psychological effects of severe stresses can be much more disabling than originally expected and leave behind scars in the mind that never heal completely.

An understanding of the psychological responses to war can be gained through studies of such disasters which give an opportunity for more detailed analysis. For any one village or individual, a particular event, such as a bombing raid or search and destroy operation, could take on the dimensions of a disaster. These single disasters may then overlap one another to form the background of a chronic war situation. Thus, both in terms of severity and duration, the stresses of war make for prolonged and exceptionally severe disaster.

Prof. John Wilson (1988) has developed a person-environment interactional model to explain the various types of traumatic stress responses (Table I). "As with any psychological response, environmental variables-namely, the external characteristics of the stressor-interact with individual psychological factors to shape the traumatic experience The immediate response to the traumatic experience will manifest in the body and mind as reactions in the neurophysiological system, in emotional and cognitive functions and outwardly in observable behaviour. These physical and psychological changes form the basis for the Post Stress Response which follows a common pathway in all traumatised individuals (Horowitz,1986). Pathological intensification of the basic stress response

TABLE. 1 PSYCHOLOGICAL RESPONSES TO TRAUMA

(Modified from Wilson (1988) & Horowitz (1986)



due to severity or chronicity of the stressor or personal vulnerability can cause a variety of mental disorders. PTSD, Anxiety and Depression are common mental disorders that have been found to occur following traumatic experiences.

Prof. Wilson's interactional model and Prof. Horowitz's Post Stress Response will form the framework (Table 1) for the description of psychological response to war stresses that follows, while Prof. Raphael's excellent account will provide the substance, interpreted through observations and experiences in Northern Sri Lanka. As Table 1 forms the key to the structure of the whole chapter, it is hoped the reader will refer to this important table frequently while going through this chapter. To make the following sections easy to follow and understand, numbering has been introduced for the subheadings of this chapter only.

1. Environmental Variables

Traumatic stress refers to unusually severe or catastrophic environmental events so traumatising as to produce significant distress in nearly all people. Although war trauma frequently involves exposure to threatening or destructive physical forces, it is the psychological impact-characterized by intense fear, helplessness, loss of control, and the perceived threat of annihilation-that constitutes its most fundamental and enduring dimension (Andreason,1985). Trauma is a "blow to the psyche that breaks through one's defenses so suddenly and with such force that one can't respond effectively" (Erikson,1986). Stress according to Sir Linford Rees (1975) is an environmental event of "such a degree in terms of strength or intensity or duration as to tax the adaptive capacity of the organism to its limit, and which in certain circumstances can lead to a disorganisation of behaviour or maladaption or dysfunction which may lead to disease".

1.1. Dimensions

In discussing war stress, it is useful to consider them in dimensions of time, space and severity.

1.1.1. Time

It is useful to divide the temporal occurrence of a traumatic event-for example, an aerial bombing raid on a village-into three phases, ***pre-impact, impact, recoil*** and ***post-traumatic*** periods. The **pre-impact period** will consist of a ***threat*** and ***warning*** phase. Each phase

TABLE. 2 TEMPORAL DIMENSION OF DISASTER

(Modified from Sims (1983) and Kinston & Rosser)

Feature	Threat	Warning	Impact	Recoil	Post-Trauma
Duration	Time Months	Minutes-Hours	Seconds-Minutes	Hours	Months-years
Cognition	Expectation, anticipation, worry, threat, preparation	Warning messages Emergency/ denial	Shock	Relief	Inventory, loss, reality sense, coping
Emotion	Fear, Anxiety, Insomnia	Apprehension, arousal, panic	Panic, shock, helplessness	Daze, inhibition, numbing, euphoria, emotional release	Grief, sadness, anger, hostility, despair
Behaviour	Preparatory activity,	Protective action, Seeking safety, displacement,	Self-preservation, Survival, Flight or fight	Hypo or Hyper activity Rescue/ Relief	Organized reconstruction Adaptation
Mental Reaction	Generalized Anxiety Disorder (GAD)	Panic	Shock	Acute Stress Reaction	Phobic Anxiety Depression Alcohol & Drug abuse Anti-social Personality Developmental Disorders Suicide
Social	Family & friends support and help. Long-term plans	Rumours, herd-instinct, gathering together, evacuation	Family unity, Clinging, Hierarchical roles	Therapeutic Community, Social unity, Breakdown of social barriers, Loss of communality, Social chaos	Refugees, Rehabilitation, Reconstruction, Recovery, Restitution, Resettlement, Social & Cultural changes

will have its own stresses and manifest in the ***individual psyche*** as well as social phenomena ***(Table 2).*** The individual psychological responses will include ***cognitive, emotional*** & ***behavioural*** components.

1.1.1.1. Threat

Before impact there can be a period of threat when there is expectation of a stressful event such as the outbreak of hostilities or an army operation. Psychologically there will be generalised fear and worry manifesting as 'free floating' anxiety, disturbed sleep and agitation. People will prepare for the oncoming war by such activities as storing food and other supplies, digging bunkers or emigrating to other areas including foreign countries. The family relations and friends will support and help one another to accomplish these tasks.

1.1.1.2. Warning

In the next phase there will be a warning of approaching danger such as declaration of curfew, radio announcements, leaflets dropped from helicopters or more imminently the sound of diving bombers or sirens before shelling (e.g. Jaffna town, 1986) and is a period of high arousal, apprehension and fear. Panic can occur. People will take urgent action to protect themselves and others like seeking safe places (temples, schools, bunkers or flee the area). Some individuals may deny or ignore the imminent danger, thus exposing themselves to risk. On the social level people may gather together, evacuate or get ready, in an organised manner. Contrariwise there may be unconfirmed rumours, spread of panic and herd instinct.

1.1.1.3. Impact

The impact stage is when the disaster strikes, (e.g. bombs explode) bringing with it death, injury and destruction. During impact there is intense fear and anxiety with its physical concomitant of autonomic hyperactivity-racing heart, dry mouth, sweating and trembling, tightness and uneasiness inside, increased micturition or defecation and tenseness of muscle (fig. 2). There is heightened arousal and attention with scanning of the environment for cues as to the level of danger, nature of the personal threat, and avenues for safety or escape. Survival or self-preservation is the chief goal. Thus, the individual is prepared for action-'flight or fight'. Most people will behave appropriately to protect themselves and significant others. Sometimes the person may exhibit power, strength and speed

far beyond usual levels, to drive their flight and get them to safety, or enable them to protect themselves or others. A well known phenomena is stress analgesia, the person not realising the extent and severity of his injuries and carrying on despite major disabilities like fractures. Flight itself may be a terrifying option, for example fleeing from the middle of fighting would mean exposure to the cross-fire. Some individuals may exhibit altruistic and courageous behaviour, risking their lives to protect and save others.

Family oriented behaviour, to save each other, mother using her body to protect her children, intense concern and frantic searching for those not accounted for, hierarchical roles of caring with men protecting the women and the women caring for the children, is often seen. There may be clinging onto others seeking the reassurance experienced in sharing the terror. Protective postures such as taking cover behind something perceived as strong or safe as inside an air-raid shelter, crawling under a bed or even the infantile posture of being curled over, head down, knees bent, and hands or arms protecting the head and face may be seen. Or the person may fling themselves flat, getting a sense of security from the contact of his body with the firm earth. When there has been little or no warning, traumatic shock will be a prominent effect of the impact. Rarely there may be intense panic or paralysis of action that inhibits and delays the person's response. Thus, in a state of shock the person may become rooted to the spot, unable to move.

A sense of helplessness against powerful forces, one's ineffectiveness and inadequacy, may cause the traumatic imprinting of the impact in vivid detail and later, during recovery, the traumatic event may have to be repeatedly re-experienced as recurrent, intrusive recollections, images or dreams to be given meaning and assimilated by the individual.

A sense of abandonment may be a powerful and frightening component of the feeling of helplessness. The person or group may feel forsaken by God and man. Children who are separated from their parents may especially feel that all the trusted, good and protective people have deserted them. Even adults can lose their sense of being safe or invulnerable, or protected, of having others who care for them.

The yearning for relief and rescue is intense. Prayers, rosaries or mantras may be repeated incessantly. They search the environment for cues of the end, for rescue and relief. Omens are magically interpreted and waves of hope follow even minimal signs. The victims are often dazed, numbed and passive; they may show Acute Stress Reactions or inappropriate apathetic and automatic behaviour (Shore et al, 1986). The Acute Stress

Reaction earlier called 'disaster syndrome' is a psychologically determined response that commonly defends the individual against being overwhelmed by the traumatic experience. Usually, this syndrome is transient, giving way to hyperactivity or to appropriate activity (Raphael,1986). But in a few, it may persist in a reduced form as a numbing of general responsiveness and avoidance behaviour. Contrariwise heroic activity may involve rescuing those affected, helping and assisting those injured and initiating relief operations.

1.1.1.4. Recoil

During the recoil period one may experience 'post traumatic utopia' due to the euphoria at having survived in the face of death and destruction, denial of loss, the breakdown of social barriers of class, caste, or forgetting of old quarrels, the mutual reinforcement of the shared experiences and the altruistic and 'therapeutic community' response of those helping and caring, can lead to elation of emotions. In contrast there can be disruption of all services, breakdown in community functioning and complete chaos.

1.1.1.5. Post-trauma

In the post-traumatic period that follows, the reality of loss, death, and destruction, the unalterable facts of changes in community and personal life and the prolonged issues of restitution and recovery must be faced. With the passage of time, decline in attention, breakdown of informal support networks, as well as withdrawal of relief and professional assistance all contribute to grief, anger and sense of disillusionment in those affected. Particularly potent in this context is the attitude of others who may now be likely to make the victims feel that they should have recovered and be 'back to normal' and no longer in need of special interest or support (Raphael,1986). Psychological reactions include PTSD, anxiety disorder, depression, family and marital discord, relationship problems, alcohol and drug abuse and psychosomatic disorder.

The last phase involves taking inventory of the destruction and loss, re-establishing reality sense and then restitution and recovery, working through the traumatic experience and readaptation at the individual and community level. A process which can be prolonged, taking years, sometimes never resolving, leaving the individual mentally scarred, handicapped and disabled. Long-time sequelae include developmental disorders in children, anti-social personality and suicide. Rehabilitation and resettlement may bring about permanent changes in cultural values, economy, religious and political beliefs. A new chapter in the life of the community may begin with the end of the war.

1.1.1.6. Chronic trauma

Temporally, in addition to the immediate acute stress, prolonged chronic stresses like living under conditions of prolonged but unpredictable shelling or the indirect effects of war such as unemployment, poverty, hunger and refugee life can produce, in time, psychological effects. Prominent are development of feelings of hopelessness, despair or depression which can end in suicide. This has been aptly termed 'continuous traumatic stress syndrome' (Shaker et al,1986).

In some the psychological responses may be delayed, manifesting in 'rebound' increase of psychological problems once the acute stress period is over (Tan et al,1973; Nasr et al,1983). Thus, in times of ease in the fighting (e.g. temporary cease fires, cessation of hostilities, Peace Accords) there is an observable increase in the number seeking psychological help. The explanation is that during acute emergencies, physical safety, treatment of injuries, food and shelter take priority while emotional problems are suppressed or ignored. Once there is some reduction in the acute stress, the psychological problems will come to the forefront.

1.1.2. Space

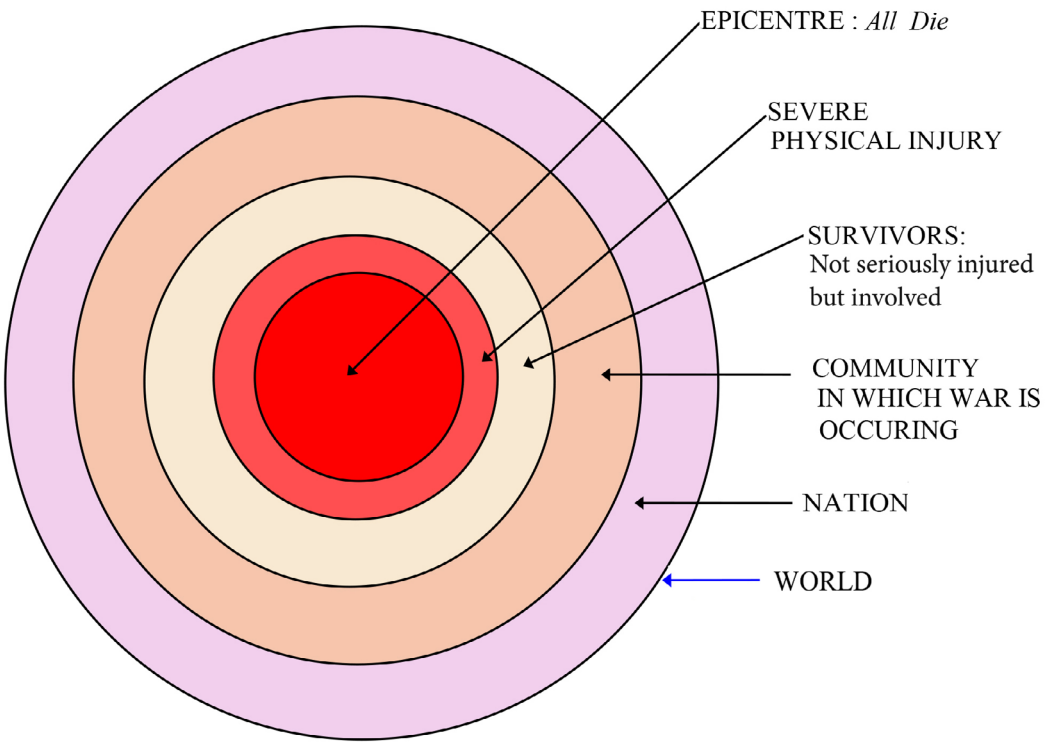


Fig. 1
Spatial Dimension of War Trauma (From Since, 1993)

Spatially the involvement of an individual or community in a given traumatic event will depend on where they are in reference to the site of maximum impact (see fig. 1). At the epicentre, where the bombs fall, all may die or be severely injured or maimed. A little further on, survivors may have felt the full impact and experienced the terror but not suffered major injury. More peripherally, witnesses may have seen the planes and heard the explosion, experienced fear and taken shelter while the larger community may only come to hear of the event second hand or through the media. Yet some in the community may have relatives or friends who are dead or injured, or take part in the rescue and relief. All these grades of exposure or involvement, may give rise to a variety of psychological response and sequelae. As the war goes on and fighting takes place in different places, concentric circles of involvement will fan out from different centres, like throwing several stones into a pond to create waves originating from different points of impact, which will overlap and blend together till the whole community is eventually immersed or overwhelmed by multiple waves of a chronic war situation. A good example of the differential effect of trauma depending on the distance from impact was the study of the psychological reactions to the cyclone that hit Eastern Sri Lanka in 1978. It was found that those in the direct path of the cyclone were markedly more affected mentally (77%) than those in the periphery (4%). Similarly in 1990 when the army moved from Karainagar Naval Base to Mandaitivu through Kayts, the people living in the direct path of the army were found to have an increased incidence and severity of post traumatic stress reactions than those living further away in the islands.

1.1.2. Severity

War stresses are often much more severe, often of a catastrophic nature, and usually multiple when compared to the stresses of normal life. Although the impact of the stress will depend to some extent on the individual perception and appraisal of the threat, war stresses are usually of such a degree as to cause distress in almost everyone. In time, many people may adapt to certain amount of stress. In Northern Sri Lanka too, one was able to observe a gradual adaptation to war events. For example, a shooting incident in 1983 caused general tension and people kept indoors for over two months. After some years of the war people could be seen about their daily chores amidst much more destructive and devastating events. While helicopters were strafing on one side, cycles and buses would be plying along the next street. Neverthelss, this adaptation to stress, where the abnormal becomes the normal, is only superficial and marks an increasing strain to cope in very pathological conditions (Heskin,1988). However, certain extreme

stresses like torture are beyond the coping capacity of all. Further, stress can also cumulative, small stresses may build up over time which can cause a breakdown, whereas each stress by itself may not be sufficient to cause major problems. A very minor stress can then act as the final straw on the camels back, taxing a persons coping capacity beyond the limit. Chronic stresses are usually of this nature.

1.2. Type

The type of traumatic event includes loss, life threat, displacement, torture, rape, and indirect effects like illness, lack of food, unemployment, poverty etc.

1.2.1. Loss

Losses during conflict occur on multiple levels and take various forms. These include the loss of loved ones-family members, relatives, friends, and respected community leaders-as well as the loss of home, pets, domestic animals, and property. Indirect losses may encompass deprivation of nutrition, food, employment, income, trust in others, and a pervasive sense of insecurity. Sexual violence can lead to the loss of chastity, virginity, and self-respect; torture results in the erosion of self-dignity, integrity, and personality; displacement causes the loss of communality and the support networks provided by neighbors and village life. Such losses, differing in degree and nature, become tragically commonplace in war-affected populations Psychodynamically loss has been found to cause reactive depression.

Of particular importance to post-traumatic morbidities is bereavement. Death of loved ones in war is often sudden and takes place under terrible and tragic circumstances. Many aspects of war deaths make for high-risk bereavements and greatly increases the likelihood of pathological or atypical grief reaction occurring as a consequence, rather than normal mourning and acceptance. Deaths are unexpected and sudden, often involve mutilating injuries and bleeding. The relations may have to witness the pain, suffering and agony of death while standing helplessly by. The death scene and images may be vividly imprinted to reappear in day time or in dreams.

A person may die in an army or detention camp. There is often a period of waiting and uncertainty, until their death is confirmed. During this period, the worst is feared but there is hope, yearning, praying and bargaining or begging with God that it be not so. Frantic searching, inquiring from authorities, desperate seeking from camp to camp is often seen. The bereaved may search for the dead person in areas where the death

occurred, at times at great risk while the fighting is still going on or during curfew hours. The body may not be found or returned or be severely mutilated, bloated, decomposed or otherwise unrecognisable. The body may have been burnt or the person may have been 'disappeared' (see Chapter 2) where the authorities deny any knowledge of the person. All this leaves a degree of uncertainty, lingering doubts, perhaps even unrealistic hope of a miraculous return, so much so that there is no finality or closure of the event.

At times the final rites may not be held. The 'body' may not be available: or the ongoing situation, curfew, flight or the authorities may dictate that nothing but a perfunctory burial be held. In a culture where the funeral ceremonies have important social and individual functions, its absence can seriously hamper the healthy resolution of grief. In addition to activating the social support network and caring responses from relations, the elaborate rituals provide for the proper expression and catharsis of grief through crying, weeping (opari), talking etc. The completion of the final obligations (Pirith) and anniversary observation allow the bereaved family members a sense of peace and satisfaction through accomplishing their prescribed duties. Thus, due to the tense and uncertain post-traumatic milieu, the healing process of mourning is blocked.

1.2.2. Life Threat

Foremost in war stresses is the threat to life which can produce intense anxiety or terror. Perceptual awareness of the threat can vary, as can the appraisal of the reality of threat. From an awareness that one very nearly died (near-miss) to the realization that one could have been there (remote-miss) can all have different degrees of impact. The encounter or brush with death can be the beginning of existential anxiety, 'loss of innocence' about personal invulnerability and a general re-thinking about life as the individual attempts to cope by integrating the experience into pre-existing inner perceptions. Near-Death Experiences (NDE) can bring on a rapid review of life, sometimes in the form of panoramic memories flashing before the mind. A person's behaviour during the life-threat may influence his post-traumatic perceptions and adaptations. Thus, one may emerge with a positive sense of mastery and courage, feeling as though one has beaten death or been helpful to others; alternatively, feelings of vulnerability, inadequacy, shame, and failure may dominate. The experience itself may leave a lasting imprint that is the source of recurrent images, nightmares and panic attacks. A full blown anxiety neurosis or a PTSD is a common sequelae.

Massive, shocking and sudden confrontation with the death of others, particularly if they involve mutilated and disfigured bodies, is extremely traumatising. The degrees of

exposure, or saturation with death, and the grotesqueness of alterations in body shapes leads to what Lifton (1967) called the 'death imprint' a jarring awareness of the fact of death, as well as of its extent and violence. Death imagery is a very important component of the response to massive death. The sights, sounds, smells, bodily mutilation, the death of children, all leave a lasting imprint. Intrusive memories or nightmares, of a body or bodies, of disfigurement or blood, may occur as flash backs by day or disrupt sleep at night. Triggers-smells, reminders by word, similarities of situation or place-may bring back all the emotional intensity of the original experience with the concomitant anxiety even when it seems shut out and forgotten. These intrusive images and dreams may alternate with defensive shutting out and repression of the memories to produce the typical PTSD. Psychic numbing can predominate, manifesting as a denial and avoidance behaviour, and progress to depression.

1.2.3. Displacement-Refugees*

The bonds to home, soil and village are powerful ones. The home is a place of protection, safety, and sanctuary. It represents the identity and closeness of the family and is the private territory of man in his familiar environment. The neighbourhood and community provide the points of reference, the daily rhythm and meaning to existence. Great indeed must be the stress that forces man to abandon his home and familiar environment, to seek a refuge in a foreign and strange place. The fear of death and persecution, the destruction and devastation of the homeland, the concern for safety of loved ones, sets in motion the basic biological mechanism of flight and the psychological trauma of being uprooted.

The psychological consequences of displacement begins with the handicap of the initial trauma with its attendant loss, death and destruction and other stressors already discussed. The immediate need is safety and shelter and this is often sought with relations and friends or in refugee camps. These temporary arrangements, especially if prolonged, can become extremely stressful in themselves. The crowded conditions, sharing of inadequate facilities, inconvenience and poor sanitation, lack of privacy and other interferences, concerns and worries of the inmates, the ongoing war and the consequent fear and uncertainty can all produce tensions and conflicts within the refugee population (Raphael, 1986). Refugees have often lost everything and have to depend on others for

* Though the term refugee denotes according to the UN definition someone who crosses international borders due to fear of persecution, the term will be used here as it is in Sri Lanka, where all displaced persons, internal and external, seeking a safe place are called refugees.

their basic needs. This often leads to loss of self-esteem, dignity and feeling of helplessness and dependency. They have to adapt to a new environment which can cause relationship problems and suspicion. Disruption of social network leads to what Erikson (1976) called 'loss of communality'. Services are often poorly organised or completely lacking in war situations leaving the refugees uncared for. Family problems can arise due to misunderstandings, lack of space due to overcrowding and trauma in members.

Children's behaviour, though restrained initially, can create additional burdens in a crowded situation. The support of the extended family is not available to resolve much of this minor conflict and tension. A social pathology in the form of family violence, aggression, theft, delinquency, alcoholism and 'perceived immorality' (Erikson,1976), can increase in refugee populations, perhaps due to acting out of trauma-induced tension and self-destructive reaction linked to unresolved anger (Raphael,1986).

When families move in with relations and friends, in time, their relationships can become strained due to crowding, lack of ongoing constructive activity or employment, minor misunderstandings and tangled interpersonal relationships.

At times the ongoing conflict can generate tensions that are displaced onto the refugees. Thus, many Jaffna Tamils who sought refuge in Colombo often with their near relations after the massive exodus in October, 1995 soon found themselves being blamed for the situation, treated with deep suspicion and turned out by their kith and kin.

Others may begin the long, complicated journey to foreign lands. The problems faced by refugees seeking asylum abroad are compounded by having to first face unsympathetic and hostile authorities and later adapt to a new culture and integrate into a different society. Sometimes called 'culture shock' the difficulties of acclimatisation to Western life styles by people coming from traditional societies can be immense. European studies of refugees indicate increased risk for mental illness. Udo Beyer (1988) describes the plight of refugees in graphic detail.

Many Tamils abroad developed various types of mental disorders and some were forced to return when treatment in the host country proved inadequate. Indeed one study found that the risk of having developed mental illness in those returning to Jaffna was high (Dept. of Community Medicine, 1995).

The world-wide refugee crisis has reached enormous proportions. There are estimated to be 15 million recognised refugees in the world today. Taking into account displaced persons within countries, the estimation is around 50 million. The Tamil Diaspora starting in the wake of the 1958 race riots is estimated to have removed more than 50%

of the population from their homes. The early migrants were well educated (contributing to the crippling brain drain from the home community) and have integrated well into their host country. The present wave of refugees starting from the 1983 ethnic holocaust have suffered a worse fate. They have had to face increasing restrictions and barriers and have been detained in camps or even forcefully repatriated. Of course, a large part of the refugee population fled to India where they were well received. The process of repatriation with varying degrees of compulsion-refoulement (Ruiz,1994) and resettlement has been started with the Indo-Lanka accord of 1987. There has also been the more tragic problem of the internal refugees, displaced from one part of Sri Lanka to another, involving all three communities-Sinhala, Tamil and Muslim. It was perhaps a 'reaction formation' that the state was promoting an international awareness for the need for shelter and actively campaigning abroad for the UN declaration of 1987 as 'The Year of Shelter For the Homeless' while so many homes were being destroyed locally due to the ongoing war, creating a large refugee population.. This refugee population have become the forgotten symbols of war-uncared for and rejected by all, and a daunting challenge to post-war rehabilitation and resettlement.

1.2.4. Torture

Torture has become a method of political control when other means, democratic or otherwise, fail or when the organization feels its grip on power weakening. It becomes a means to maintaining power by coercion and terror. Torture is used not only to interrogate and extract information, but also to punish and deter opposition by instilling fear-fear of being painfully tortured, not just killed-unless one follows the dictates of that organization, whether it's the state or any other group. The inner resistance, ideological commitment, identity, self-respect and personality of an individual are systematically destroyed by a judicious mixture of physical and psychological pain. It is becoming increasingly recognized by those in the game of power that simple physical control is not enough. War is no longer a straight forward destruction of each other till one submits. Thus, it has become more a psychological battle for the mind. Control of mind through fear and terror appears easier and more direct. Often torture, as practised by all parties to the conflict in Sri Lanka, becomes one aspect of institutionalized violence, resorted routinely against those suspected of being opposed to the particular state or group.

Many do not survive torture, but those who do, do so by adopting resilient coping strategies in the face of severe and abnormal stress. The short and long-term neuropsychological sequelae to torture can be seen as 'meaningful reactions of a sound and forceful constitution

that make survival possible in a very pathological situation' (Trautman,1964), for most of these victims were robust and healthy youths who set out with idealism and altruism to change society for the better and redress the injustices against their community. When we see them broken and helpless after torture, we have to accept that this is the price they had to pay to survive. It has been found that the long and short-term effects of torture are much more severe in those who were 'innocent' to start with, with no ideological commitment to sustain them, being the victims of arbitrary arrest, detention and torture (see Chapter 7).

Much of the sequelae to torture is similar to the post-traumatic stress response syndrome and their pathological intensification (vide infra). Thus, PTSD is common as are anxiety and depression, but in addition many show signs of personality destruction-deep suspicion and mistrust of the world, severe social withdrawal, impaired interpersonal relationships and poor social skills. Severe phobia, avoidance of any stimuli that evokes re-experiencing the torture, sleep disturbances with nightmares and night terrors, impaired memory and concentration are all frequent symptoms. Due to the physical methods of torture, complaints of pain are very common. These include musculoskeletal pain-especially over scar tissue on the head, back, soles, and hands-as well as psychosomatic symptoms such as headaches, muscle tension, shortness of breath, chest pain, indigestion, and backache. Most investigators report that these physical and neuropsychological sequelae show poor tendency to spontaneous recovery (Ortaann et al, 1987) leaving the victims physically, emotionally and socially handicapped for life. Fortunately, workers in the field have found that positive therapeutic intervention can help many of these 'survivors' to regain their self-respect and build a hopeful future (see Chapter 8).

Unfortunately, in our cultural setting, due to lack of understanding about the psychological consequences of torture, the stigma attached to acknowledging any form of mental disorder and the severe social withdrawal that is a sequelae to detention and torture, many who need help do not come forward for treatment. They commonly 'somatise' their psychological and social problems in bodily terms and present themselves to traditional healers, general practice and out-patient departments with physical complaints or withdraw from society all together.

1.2.5. Indirect Effects

Apart from the direct stressors of war, the many long term consequences on the economy, essential service, social systems and life patterns produce considerable stress. These may be called the secondary stressors. The destruction of property, occupational equipment

and cultivations; displacement from place of work; restrictions on fishing, travel and transport of fertilisers, spare parts, fuel or fresh products for the market; lack of electricity or other necessary items such as cement, wood and the like has meant loss of employment and income for many. Hardest hit were the daily wage earners, fishermen and farmers. Masons, carpenters, electricians and other skilled workers soon found themselves out of work. Refugees had no income and were completely dependent on 'hand outs' and relief rations. Increase in prices and cost of living, shortage of essential items and the decline in the circulation of money has compounded the problems. Many have been pushed below the poverty line, some with no income at all, with attendant lack of food and essential items. Most worrying has been malnutrition in children with the possibilitie of permanent brain damage (Sivrajah,1993). Shortages of drugs, immunisation agents, medical personnel and services has produced increased morbidity and mortality in the population (Natchinakiniyan,1994).

The disruption of essential services and schooling interferes with the daily life of the community. Some individuals who were previously active and engaged find unemployment and prolonged inactivity to be deeply depressing. Thus, for many reasons, the indirect effects of war have the cumulative effect of slowly eroding the morale of the general population, pushing them to the brink of hopelessness and despair. In time some began to feel that they have reached the end of their tether, that they can't go on like this anymore and may contemplate or attempt suicide.

1.3. Post traumatic milieu

An ongoing war with an atmosphere of fear, tension, hostility and uncertainty is hardly the best environment to effect healing and return to normalcy. Firstly, the prevailing situation will continue to generate further insults to add onto the pre-existing stressors. Secondly, the usual social economic and personal support networks present in normal times will be totally absent or function inadequately. Ideally these community resources go into forming a 'protective membrane around the victims to insulate (envelope) them from further stress or harm'-the so-called trauma membrane (Erikson,1976). The immediate and extended family gather around an effected individual to support, nurture and work through their traumatic experience. But in a war, the basic family unit itself may be directly affected and the trauma membrane ruptured. Economic resources in the form of employment, loans for rehabilitation, resettlement and rebuilding or funds for mere existence is of crucial importance in determining post-traumatic adaptation.

Socio-cultural attitudes and responses towards the victimised individual and the war

itself can be strongly influential on post-traumatic adaptation. For example, the ambivalence and rejection of returning Vietnam war veterans in the US contributed to their post-war problems of adjustment. Societal and political attitudes toward traumatised individuals are important aspects of the recovery environment, for they determine how resources will be allocated to provide the services that are needed by the victims. In designing a rehabilitation program for veterans and combatants returning back to their community, effort has to be made to create opportunity structures, respectful employment and careers that help to assume commensurate personal responsibilities and establish viable personal identity that has meaning and significance within the society (Wilson,1988). These vital considerations were not taken into account when the war ended in 2009. While there was no demobilization in the Sri Lankan forces, militants found themselves facing continued security surveillance and negative social attitudes, leading to poor adaptation. Similarly, societal rejection of rape victims of the IPKF operation (see chap 6) has made many of them feel ostracised and shamed, forcing some to seek refuge in an impersonal foreign environment like Colombo or abroad. In an Institute of Human Rights (IHR) medical outreach project to assess and treat handicapped ex-servicemen in the Matara District, it was found that most of the discharged soldiers without limbs were secure economically, receiving good pensions, but felt neglected by the State and society. They had a deep sense of rejection that they were not being looked after, for example, the long-term care and prosthesis for their lost limbs. They felt that the State and society had just dropped them after their usefulness on the battlefield was over.

A safe and secure environment, support and sympathy from others, and opportunities for rehabilitation contribute towards healthy post-traumatic recovery.

2. Personal Variables

The environmental and situational variables, work on and through the individual psyche (see Table 1). Thus, the impact of the traumatic event depends on and interacts in a myriad of ways with the personal characteristics to determine the individual's response and adaptation.

2.1. Personality

While, emphasising 'the wide variety of human responses to similar trauma', McFarlane (1988) found, among fire fighters exposed to a bush fire disaster in Australia, that rather

than the impact of trauma itself, pre-morbid factors like 'introversion, neuroticism, past history and family history of psychiatric disorder were significantly associated with the development of chronic post-traumatic morbidity'. Of these, neuroticism appeared to be the predominant personality trait playing an aetiological role. Some individuals, by their past experience or genetic vulnerability, may have a lower threshold for developing post traumatic disorders. According to Horowitz (1986), an individual's character style (e.g., paranoid, hysterical, obsessional) significantly influences how they perceive and respond to a stressful event. The initial appraisal of the event, as traumatising or not, may determine post-traumatic responses. It is the person's perception of the event, appraisal of the stimuli and interpretation of its meaning as threatening, harmful and endangering that is critical for the impact of the trauma. Individuals also vary in their threshold for stress. What is a traumatic experience for one person may be a challenging problem to another.

Thus, in some "the cognitive style of information processing under the conditions of stress results in a tendency towards the reduction or constriction of information from the stimulus field which, in turn, directly affects the processing of encoded information and the formulation of a schema for enactment. While in others cognitive style augments and expands the search of the stimulus field under conditions of stress. As a result, there is vigilance in processing the material encoded which can lead to effective problem solving or excessive hyper-vigilance depending on how the stressor was perceived and initially appraised during the trauma" (Wilson,1986).

Another way of understanding how personality can determine response to trauma is through the classical Hindu classification of Gunas. The 'Tamas' personality will constrict and reduce perception, denying or distorting the event and react passively or withdraw from the situation. The 'Rajas' personality will vigilantly search the stimulus field and actively meet the challenge with a vigorous, heroic response. The 'Sattvic' personality will show accurate appraisal of the event while reacting in a balanced and judicious way.

2.2. Hereditary

As already mentioned, hereditary factors may determine the personality, as well as the predisposition to particular reaction patterns. Individuals with a family history of mental disorder are more likely to develop the same type of mental illness under stress. Thus, in individuals with a genetic vulnerability to schizophrenia, severe stress can act as a precipitating factor for the onset of the illness. The same holds true for affective disorders.

2.3. Role, Beliefs & Attitudes

The role an individual plays in the stressful event has a significant influence on the outcome of the response. The great majority caught in the war in Sri Lanka were civilians whose role was passive and inactive. There was a sense of helplessness in that they had no influence on the course of events. It appeared quite arbitrary who would be trapped in any particular event and many carried on from day to day hoping that it wouldn't be them. The concept of locus of control-whether perceived as internal (under the individual's control) or external (determined by outside forces)-has been found to play a significant role in stress responses and psychological adaptation. A locus of control seen as outside oneself can give rise to 'learned helplessness' and maladaptive reactions, including depression. On the other hand, those taking an active role can develop feelings of mastery and control over events, or contrariwise, disillusionment and frustration when things don't work out as they expected. Further, it has been found that man-made disasters like war are more traumatising for the victim than natural disasters due to attribution of casualty. Natural disasters are taken with resignation to fate, while when men are responsible there is anger and rage.

It is not still clear, however, whether such issues as guilt, loss of control and powerlessness, so important in the West, are equally relevant in the East. For example, shame, loss of face, trust, fate and blame can be more crucial in Eastern settings. The locus of control described as a fundamental factor of traumatization in the west, may be based on the cultural illusion of control the individual is said to possess. The emphasis on individual responsibility-and, by extension, human rights-leads to a corresponding sense of guilt based on these beliefs. In Western societies, particularly in the United States, the individual or ego is seen as the center of the universe, perceived as being in control and responsible for every action (see Fig. 1 in Chapter 3). Ironically, however, the social sciences-such as sociology, economics, and the behavioral sciences-often emphasize that human behavior is shaped and constrained by larger, supra-individual forces. In contrast, in the East, beliefs in karma, fate and the links to family, group, community and ancestors make the worldview very different. A person may think not from an individual point of view but from a family or village perspective. Even more different are concepts regarding the self and time which are distinct from the ones prevalent in the West (Van de Put, 1997). These considerations are vital for trauma therapy. As such, a Western trained psychotherapist will find it difficult to understand the socio-cultural context and belief systems of the East, making it that much more difficult to handle these issues with their client. Indeed, erroneous understanding and pursual of western preoccupations

with guilt can make psychotherapy a hazardous journey. It may be more prudent to leave these issues to the local priest, monk or traditional healer who will better understand the belief systems of the local population and thus may be in a better position to help.

Motives and beliefs about the war, have a strong bearing on the traumatic stress response and adaptation. Many studies have found a decrease in the incidence of mental illness and suicide rate during war times and have attributed this to the greater social cohesiveness and commitment to the cause of the war (Lyons,1971;Durkheim,1951). Writers have described the 'commune naufragium', the banding together in the face of a common enemy, and the united sense of purpose typical of wartime (Curran,1988;Fraser,1991). Thus, a strong conviction in the moral rightness of the war and motivation to resist and fight are believed to have a protective or beneficial effect on mental health.

Unfortunately for the Tamil community in Sri Lanka, despite some early unity of purpose directed against the discriminatory policies of the state, it soon became fragmented as the militants themselves became bitterly divided, pulling the community in the wake of their feuding. To a large extent, even from the beginning, the civilian population have been unwilling, non committed victims in the conflict, whose purpose and goals have increasingly become vague and contradictory. The general mood itself has changed from one of fear, terror and tension to one of disillusionment, demoralisation, despair and apathy.

2.4. Past Experience

In addition to the pre-morbid personality, the past history of the individual, for example childhood experiences of loss, separation or trauma may make the person more vulnerable to stressful events. The coping and adaptive styles or defensive mechanisms that were learned before and found to work or were positively reinforced will be used again. Previous experiences of successful coping, adaptation and mastery over stressful problems may make a person more resilient in the future. Similarly, a positive self-image, self-esteem and self-confidence may herald a positive outcome, while a negative self-image may make it more likely that the individual will 'succumb' to the stress. A form of 'learned helplessness' will set in. This knowledge has been used to prevent development of stress reactions by exposing or dosing the individual beforehand with stimulated, attenuated forms of the stress he or she is likely to meet. They are then encouraged to try out and rehearse various coping strategies. This method of stress inoculation was used in UN troops before the recent war with Iraq (Desert Storm) and in astronauts before they go into space.

2.5. Age

Of the person variables, age is an important factor. Children respond to traumatic events differently than do adults.

2.5.1. Children

Initially, children appear to be much more resilient to stress, showing little ill effects. Lyons (1971) says that in Northern Ireland, "In the short term many children seem to find the disturbances an exciting, proximate and novel experience and are remarkably resilient to the stress of rioting, bombing and shooting".

Bodman (1941) reports of World War II air raids: "Many children regarded the experiences an adventure and the general impression was of the extraordinary toughness of the child and his flexibility in adapting to potentially dangerous situations".

Children though very frightened by war events, usually respond directly and appropriately to the threat they appraise and rarely show adult defensive mechanisms like psychic numbing. In some circumstances where parents have regressed in the face of traumatic events, or died or were otherwise not present, children have taken over adult roles and acted responsibly. It is not the traumatic events so much as the lack of emotional support, separation from parents or family disruption, and the communicated anxiety, grief and distress of parents and adults that are a source of psychological impact for the child.

At an age when the child is not able to understand the full significance of events or conceptualise the permanency of loss or death, it is the parents, elders and teachers who, by their behaviour, verbal and non-verbal cues and nature of interaction, give meaning and interpret events for the child. If provided with a nurturant, supportive, secure and trusting atmosphere, one can expect the child to cope well.

But in the long term, when the disrupting and devastating events of the war continue, when no safe and secure haven is available for the child to settle down and when the parents themselves are emotionally affected or worse, missing or dead, the child is put under enormous strain. This 'time course of response pattern' can be commonly observed in refugee children (Raphael, 1986).

The long term responses of children to death, destruction, and disruption may not be easily recognised by adults, as children cannot verbally express their feelings and experiences. Yet, many studies in war situations by trained child psychiatrists and psychologists who are able to detect and recognise the signs and symptoms or traumatised

children report devastating effects (Richman et al,1988; CRC, 1986; Allodi, 1986).

Some common war stresses in children (Richman et al, 1988):

- **Malnutrition and poverty:-** Parents not working, homes and agricultural fields destroyed, high prices and shortages etc.
- **Ill health:-** Poor sanitation, reduced resistance, increase in communicable diseases, poor health services, injury, disability.
- **Displacement:-** Change from home, environment, school.
- **Loss and bereavement:-** Separation from parents who are dead or detained.
- **Witnessing violence:-** Often towards family and friends (killings are usually extremely brutal and includes shooting, stabbing, and hacking people to death with axes), seeing mutilated, dismembered and decaying bodies; seeing the destruction of home and other institutions.
- **Experiencing violence:-** Bombing, strafing, massacres, search and destroy operations, assault and harassment.
- **Being compelled to commit violence:-** Recruitment, military activities, including murder as child soldiers.
- **Disturbance in Education:-** Disruption in regular schooling and education has been a prominent stressor in this war(inability to attend school due to displacements: unavailability of schools due to destruction or use as camps); indefiniteness about the national exams; lack of a secure, calm, well lit (no electricity), quiet environment for learning; irregular attendance due to transport difficulties and war situation, students being detained, conscripted, indoctrinated or forced to partake in political activities; seeing the emigration of fellow students; lack of opportunity to continue their education (refugee children being unable to go to school due to lack of uniforms, exercise books and the like).

The way a child reacts to trauma will depend on his age, due to the development stage with differing motor, emotional and cognitive skills and needs. The response will also be influenced by the nature of the trauma and the way adults react. Some common responses shown by children to traumatic experiences has been described by Raphael (1986):

Separation anxiety: Children regress, are fearful and distressed when separated from parents, through death, disappearance, and displacement even temporarily; and when reunited, cling to them and wish to sleep with them again at night. Bowlby's work on

children separated from parents in war show that the symptom pattern may vary from child to child or may distil out into specific disorders such as anxiety states and depression as well as conduct disorders (Bowlby,1980).

Emotional disorders: Intense fears are associated with traumatic experiences. Any physical reminders may trigger such fears. Common stimuli that trigger phobic reactions are sudden commotions, sirens, loud bangs or fire crackers (that remind children of firing), uniformed men, helicopters and aeroplanes. There may be excessive crying, low mood, loss of energy and enthusiasm or suspicion, hostility and anger.

Sleep Disturbances: Traumatised children may find it difficult to communicate or express their emotional needs. Rather children often dream of their traumatic experience and are likely to have nightmares and night terrors where they seem to re-experience their terrifying ordeal again and again. It has been hypothesised that dreaming is a gradual method of mastery and integration of distressing experience that cannot be faced when awake as they evoke extreme anxiety. Relief may not come with these 'terror dreams' and after sometimes the traumatic experience may be represented by disguised, indirect or archetypal dreams which then tend to be repetitive.

Play: Traumatised children unable to express and release their emotions verbally or otherwise, may do so through playing, drawing, story-telling or play acting to integrate and master what has happened. Distinction is made between ordinary play, which helps children master everyday stressful experience, and traumatic play (Terr, 1981). In ordinary play, the child symbolically represents the stressful event, participants and general themes. He may take on the powerful role, directing and controlling events, caring for the hurt and helping the disabled until he masters the experience.

If children growing up in war situations are asked to draw, they will often draw pictures of war scenes, active fighting, people being killed, injured, guns, helicopters, bombers, houses burning, people (their parents) being dragged off by soldiers or shot, refugee camp life, being on the road or their house being destroyed. Often figures are disfigured, limbs may be missing, and out of proportion. These drawings indicate how strongly war events have been imprinted in the child's mind and how preoccupied the child is with these traumatic scenes.

Psychosomatic symptoms(Somatization): These are common among traumatised children. Headaches, stomach aches and other gastro-intestinal disturbances, breathing difficulties, fainting spells, 'fits', giddiness, vomiting, loss of appetite, vague pains and parasthaesias are frequent complaints.

Behavioural changes : Regression in the form of re-emergence of earlier behaviour or loss of developed skills is seen in children under stress. Thus, the child may regress to infantile like behaviour, clinging and demanding attention or insisting on sleeping with the parents. Control over sphincters may be lost and child may start bed-wetting again. Speech skills may decline or stuttering develop. Decline in academic performance and absence from school is commonly reported. Specific conduct disorders like temper tantrums, acting out behaviour, irritability, aggression, or isolation and withdrawal may manifest in traumatised children. Disciplinary difficulties, relationship problems with siblings, peers or parents can be seen and more ominously, overwhelming trauma may adversely affect the psychological development of the child. Increased incidence of juvenile delinquency in war stressed children has been reported (Lewis, 1942).

Cognitive changes: Cognitive restrictions, such as thought suppression, denial and repression; loss of concentration, memory loss, learning difficulties and a limited view of the future are striking.

Loss of Innocence : Although children may not completely comprehend the implications and finality of events, exposure to massive destruction and death will lead to what Lifton (1967) called the loss of the **"innocence of death"**. Witnessing horrifying death of loved ones, friends or strangers, seeing many mutilated or dismembered bodies, the decaying and bloated remains and the reactions of their parents and elders is bound to saturate the child's consciousness with death and brutalize his future development. Experiencing the death or powerlessness of the all-powerful parents can be especially traumatising. Similarly seeing the destruction of a previously permanent structure, his or her home, can be the collapse of everything secure and strong, of the child's known world and create a vacuum that can never be filled.

Brutalization: But beyond the immediate post-traumatic responses of children, the most tragic long term formative influence of violence is on their thinking and behaviour. As Lyons (1971) concludes: *"The long term effects on the young are very much more disturbing. Violence has become an intrinsic part of life for them. They are conditioned to it, and it has become a major part of the learning experience".*

Children growing up immersed in the war milieu, where they are exposed to violence on a large and terrible scale, death, injury and destruction learn only too easily that all life is like that. They know no other world. When violence becomes the socially accepted and acclaimed way of solving conflicts and when they don't see the successful operation of alternate methods, children when they grow up, will themselves start to adopt violent methods of solving their problems. Thus a vicious cycle is built up and a cult of violence

comes into existence. The whole atmosphere becomes poisoned with suspicion, hatred and aggression-a struggle for survival in a paranoid jungle. The child has a right to grow up in a safe and secure world (see the **Convention of the Rights of the Child**-United Nations General Assembly, 1989), which we adults deny them in our struggle for power.

2.5.2. Adolescence

Adolescence is a particularly vulnerable period. Adolescence crisis may affect the response to trauma where the adolescent tries to act like an adult by showing control and forbearance. Thus, they may bottle up their emotions and become withdrawn and depressed or alternatively act out their tensions in a reckless and aggressive way. The search for a meaningful philosophy of life and need for stable identity may, in the face of overwhelming threat, lead to rejection of perceived impotent authority, adoption of alternate role models, delinquency or joining groups and movements (see Chapter 3 for identity crisis).

2.5.3. Elderly

The elderly are more vulnerable to death, injury and displacement because, in addition to their general ill health and lack of mobility, they are more attached to homes and thus slower to move out in times of danger. Senile deterioration and confusion is precipitated by evacuation to a new environment. But as survivors they appear to more readily accept the situation with a philosophical attitude and suffer their emotional hurt quietly.

2.6. Gender

Increase psychological morbidity among women exposed to violence and war has been noted in several studies (Lyons, 1971;Durkheinm, 1951), perhaps due to extreme stresses of war, the burden of family responsibilities and loss of husband and home. The active role of man in conflicts has been hypothesised as a protective factor (Lyons,1971). In addition, the absence of men due to their active participation in the fighting, death, and migration have left the women to face the psychological trauma of war. During the war in Northern Sri Lanka there was a marked reduction in the number of young men in civilian communities; and women had to increasingly take on male roles and duties while also looking after the family and home. That women came forward to shoulder this heavy burden, thereby redeeming society at a most critical juncture is a mark of their commitment and sacrifice. But this heavy load would have placed considerable strain in women manifesting as psychological problems in many.

2.7. Groups

The trauma of the war can be experienced alone, with others, as a family or as a community and in each, different psychological processes can operate both beneficially in a supportive way, or detrimentally to cause maladaptive responses.

2.7.1. Family

Due to close and strong bonds and cohesiveness in nuclear and extended families in our cultures, the families tend to function and respond to external threat or trauma as a unit rather than as individual members. Thus, the family tends to think, feel, experience and respond together. When an event happens, the family faces it together as a unit. They share the experience and perceive the event in a particular way. Thus, it may be more appropriate to talk in terms of family dynamics in our culture rather than of individual personalities.

During times of traumatic experiences, the family will come together with solidarity to face the threat as a unit and provide mutual support, protection and hierarchical roles with each playing his part. In the early impact phase (table 2), family activity will be primarily directed at survival and staying together. Extreme sacrifices, frantic searching for absent members, courageous activity, facing inordinate risks to ensure the safety of loved ones are all common place. In time the family will act to define and interpret the traumatic event, give it structure and assign a common meaning, as well as evolve strategies to cope with the stress. In this process they will share their experiences, support each other, and help to work through and come to terms with the trauma. More importance will be given to themes and issues of family importance. What matters will be the survival of the family, its values and beliefs, that may even be generational. The family name, the family honour may need to be protected. The family dynamics will function as if each member is one part of a bigger organism.

Thus, efforts should be taken to keep the family together and united. Family cohesion should be strengthened. Family dynamics can be improved by fostering mutual trust and encouraging interdependence of its members. Traditional roles may have to be re-established. These considerations can hold true for the extended family as well. Absence of members of the family due to death, injury or displacement will create infallible gaps in the functioning of the family unit. The uncertainty or grief about the missing member will add to the maladaptive family dynamics that may ensue. The loss of the essential unifying role of the missing member can cause disruption and disharmony within the family.

The Danish group working with refugee Chilean children whose parents had been tortured, found, "78% had emotional or somatic symptoms and suffer serious perhaps life long, sequelae, psychological as well as social" (Cohn et al, 1985). The loss or death of one or both parents can completely disrupt the family and cause irreparable damage in the growing children. A mother grieving over a missing husband will communicate her loss through the way she relates to her children. The altered mother-child interaction may be later reflected in the way the child, when grown up will relate to his or her children. Trans or inter generational effects on the children of traumatised victims even decades after the traumatic events have been detected in their relationships and way of life (Rosenbeck, 1988). In the same way, the loss of their children can spell the end of the purpose and meaning of life for the parents. Nevertheless, it is important to remember that a functioning family unit is the one single effective resource we have in our society to effect individual recovery and all care and guidance must be directed at strengthening and supporting the family to stay together and cope as a unit.

2.7.2. Society

The trauma of war can be experienced as a village or a community, in which case, psychological processes such as mutual support, care and nurturance by the social network; the sense of belonging and direction provided by the group; identification, social pressures, norms and rituals; as well as contagion, rumours and myths, can be observed to operate. Given the widespread nature of the traumatization due to war, the reactions have come to be accepted as a normal part of life. This normalization can be seen in the prevailing cultural coping strategies. Indeed, it would be more appropriate to talk of collective trauma (Somasundaram,1994) or cultural bereavement (Eisenbruch, 1991). In these circumstances it may be more meaningful to look at how the community as a whole has responded, how the community coped, and what we can do at the collective level (Somasundaram, 1996). For example, it may be more beneficial to consider strengthening and rebuilding the family and village structures, as well as finding a common meaning for the immense suffering and encourage community or rural development.

As discussed, social attitudes can influence how traumatised individuals are treated, their response and eventual recovery. Cultures and villages have their own rituals and traditional functions to deal with trauma. Funeral rites, the 31st day and subsequent anniversary observance are powerful social mechanisms to deal with grief and loss. The gathering together of relations, friends and the community is an important social process

to share, work through and release deep emotions, define and come to terms with what has happened and finally integrate the traumatic experience into social reality. In addition to funerals, religious and temple rites, cultural festivals, dramas, musical fares, exhibitions and other programs, meetings and social gatherings provide the opportunity for people to discuss, construct meaning, share and assimilate traumatic events. In war, when due to the disturbed situation these rituals are not possible or improperly performed, the trauma is never fully accepted or put to rest, as in the cases of "disappearances" where there is no finality about death. Ideally the social processes should work to promote feelings of belonging and participation, where the group is able to give meaning to what has happened, adapt to the new situation, and determine their future.

3. Response to Trauma

Following Professor Wilson's scheme (table 1) the environmental or situation variables of the trauma can be seen to interact with the personal characteristics of the individual to produce a response.

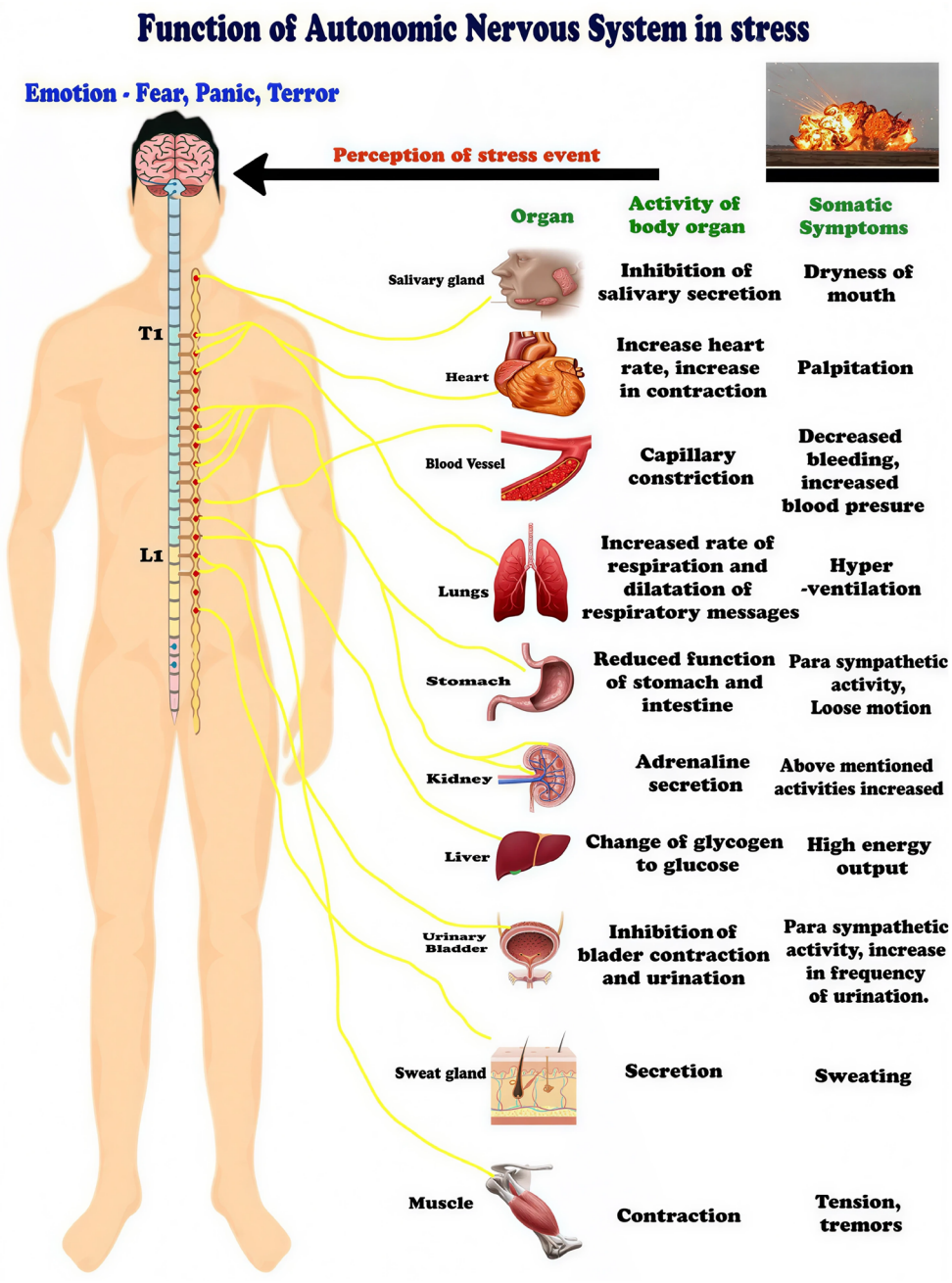
The immediate response will manifest in the mind and body. In the mind the responses are usually described under the headings of cognition, emotion and behaviour. The traumatic event is perceived by the sense and then appraised as threatening or not. This initial cognition sets off reactions in the physical body and emotions, such as fear. The total result is outwardly observable behaviour.

3.1. Physical

The nervous system connects the mind with the body. The sensory system is responsible for the perception of the traumatic event while the motor system will execute the responses, seen outwardly as behaviour. The brain/mind functions to integrate these responses through such processes as cognition and emotion. The Autonomic Nervous System (ANS) and Neuro-Endocrinal System will operate below conscious awareness to maintain the organism as well as prepare it to meet an emergency or stress. It is particularly the Sympathetic Division of the Autonomic Nervous System and the Hypothalamo-Pituitary-Adrenal Axis of the neuro-endocrinal system that are important mediators of the post traumatic stress response and responsible for much of the later somatic manifestations. The Hypothalamus is said to function as the interphase between the nervous and the endocrinal systems.

3.1.1. Nervous Response

A good framework to understand the neuro-endocrinal response to stress is what Selye (1976) termed the General Adaptation Syndrome (GAS). He divided the syndrome into the alarm reaction, stage of resistance and state of exhaustion. When an actual or anticipated event is appraised as threatening, the initial response is one of alarm, activating the reticular system in the brain stem which induces a state of alertness, attentiveness and vigilance. This alerting reaction which prepares the organism for either 'fight or flight' is mediated by the centres in the hypothalamus and reticular system of the brain for the sympathetic division of the autonomic nervous system (ANS).



-Artwork by Dr. V. Thanushiyan

Fig : 2
Function of Autonomic Nervous System in Stress

Cannon's classic description in 1929, emphasised the single, overall nature of the organism's physiological response to threatening stimuli. The effect of the sympathetic discharge (see fig 2) is to prepare the individual to cope with the emergency. The firing of the sympathetic nerves increases the heart rate and blood pressure(providing better perfusion of oxygen and energy to the vital organs and muscles), increases respiratory rate(more oxygen for metabolism and the waste carbon dioxide), elevates blood glucose and free fatty acid levels(mobilising more energy), increases muscular tension(better and quicker muscular performance), constricts blood vessels in the skin and other non-vital organs(reducing bleeding and diverts blood to muscle, heart and other vital organs), dilates the pupil and retracts the eye lids(improves vision) and increases sweating(heat loss). Stimulation of the adrenal medulla floods the system with adrenaline which augments the above responses. Simultaneously, the parasympathetic system which controls the vegetative, anabolic functions, unnecessary in an emergency, is inhibited (stops flow of secretions in the bowls, increase tone of sphincter muscles, etc.).

Although the phenomena of mass discharge, the whole system functioning as a unit is emphasised, there is wide variation in the pattern of systems affected. This phenomena of 'individual response specificity'(Lacey,1959) is shown by differences in maximum activation of, say the cardiovascular system in one individual (who will complain of palpitation), and the respiratory system in another(who will complain of breathlessness). Further the sympathetic and parasympathetic systems may be differentially activated in different organs. Some individuals thus respond to stress by evacuation of the bladder and/or bowels which are parasympathetic functions. The conscious awareness of these physiological changes (e.g., racing heart, sweating palms, dry mouth) can feed back to increase the fear and anxiety, which then activates the sympathetic centres in the brain stem(locus coeruleus) to further increase the sympathetic out flow, setting in motion a vicious cycle. When the danger signal or traumatic event is overwhelming, the person may pass into a state of psychic numbing or daze, inadequate activation or inhibition of the autonomic and motor systems, psychomotor retardation or even psychogenic stupor (paralysis). Thus, inadequate functioning can occur in both extremes of hypo or hyper arousal.

In addition to being the familiar physical symptoms of anxiety - such as palpitations, sweating, tension, tremor, breathlessness, etc. - these physiological responses may have long-term consequences. Thus, many of the somatic complaints and psychosomatic illnesses like headaches, muscular pains, hypertension, heart disease, and peptic ulcer may be linked to a state of hyper or chronic arousal and concomitant autonomic discharge. The common 'tension headaches', back aches and musculo-skeletal pains complained

of in post traumatic states is believed to be due to chronic tension and prolonged contraction of the muscles. Rapid, shallow breathing or hyperventilation (Magarian, 1982) due to emotional arousal alters the blood acidity and calcium levels producing many alarming symptoms and signs of bodily dysfunction like exhaustion, lethargy, poor concentration, memory disturbances, numbness and tingling of extremities (paraesthesias), feeling cold, giddiness, breathlessness, sighing respiration or Perumuchu Syndrome (Sreeharan, 1984) dizziness, chest pain, palpitation, muscle pain, carpo pedal spasms-tetany, anxiety and panic attacks.

3.1.2. Endocrinal Response

A later response in the alarm reaction is activation of Hypothalamo-Adrenal Axis (endocrine glands) to secrete corticosteroids. This initial response is life-saving. Animals without this endocrinal mechanism die when exposed to stress. But prolonged secretion of corticosteroids may be maladaptive and again produce a variety of psychosomatic illnesses like peptic ulcers and increased vulnerability to infection and other diseases due to reduced immunity and inflammatory response.

In the next stage of resistance, the organism is at its optimum level of adaptation and is able to cope with stress. If the stress is prolonged further, the stage of exhaustion is reached, where the adrenal cortex is depleted or no longer able to secrete corticosteroid and the organism literally gives up, becoming passive or even dying. Low adreno-cortical activity has been associated with numbing, detachment and similar psychological defense mechanisms found in post-traumatic stress disorders (PTSD) (Watson et al,1988). Thus, the stage of exhaustion and low steroid levels may be the physiological basis of the generalised suppression of affective arousal, a major criterion for diagnosing PTSD.

The secretion of opioid neuropeptides, encephalon and endorphin, have been postulated as the basis for phenomena of stress induced analgesia (Watson et al,1988). Thus, individuals under severe stress may not be aware or feel the pain of injuries like fractures and bullet wounds, and continue running or saving others, till they rest or feel safe, when the sight of blood, its wetness or intense pain alert them to their injury. Perhaps, the endogenous opioids are also the basis for the observed 'post traumatic' euphoria when there is relief over having survived.

A healthy neuro-physiological response would entail a degree of arousal and sympathetic activity that is commensurate with optimum performance and endocrinal secretion (stage of resistance). The organism is therefore well prepared to meet the challenge with all systems at peak functional capacity.

3.2. Emotional Reaction

Traumatic events produce powerful emotional reactions as they inevitably upset the psychic equilibrium.

3.2.1. Anxiety

When an individual is overwhelmed by the threat to his or her physical survival and psychic integrity, they may experience intense fear, manifested as extreme anxiety or panic with a concomitant physiological reaction, especially incapacitating sympathetic overactivity. The person may be flooded with distressing affect and be unable to cope.

3.2.2. Psychic Numbing

Faced with such a traumatising event and perhaps as a defense against the distressing effect that it does or will evoke, some persons shut down emotionally by producing affective blunting and a state of hypoarousal. Called psychic numbing by Lifton (1967), this defensive mechanism acts essentially as a protective barrier against being overwhelmed by the intensely upsetting experience. Psychic numbing has a continuum, ranging from stuporous, zombie like states to very subtle manifestations such as impacted sensuality and difficulties in giving and receiving affection. When psychic numbing is reduced, alleviated or suddenly lifted by a failure in ego-defenses or the experience intrudes into consciousness as images or in dreams, the individual may experience anxiety, vulnerability, or a fear of losing control (Wilson,1988).

3.2.3. Affective Balance

On the other hand, affective balance is a healthy response to trauma where the emotional arousal stimulates optimum neuro-physiological activity by realistic appraisal and affective adaptation to the situation.

3.3. Cognition

An individual always attempts to make meaning out of what happens and integrate it with past experiences. This processing of new information consists of selective attention, perception of the event, appraisal of the situation as threatening or not, comparison with past 'schemas' and memory, assignment of meaning, attribution of casualty and a plan of response, among others.

3.3.1. Denial

When confronted with overwhelming or threatening trauma, a person may cope by denying or avoiding full awareness of the event. This can involve inattention or blocking perception, interpreting the situation as not requiring action, or minimizing responsibility and involvement through cognitive denial, emotional withdrawal and avoidance behaviors

3.3.2. Distortion

Cognitive distortion is a similar defensive mechanism that protects against the unpleasant affect of anxiety provoked by the traumatic experience. Distortion, like denial, is a defensive cognitive style that inhibits rather than augments external and internal stimuli, by a high degree of selective attention, a narrow search of the stimulus field, and misperception. The affective arousal causes a low level of persistence or constriction in gathering information. Distortion is most obvious in the way in which opposing sides in a conflict situation perceive a given situation (see Chapter 3); or, on a social level, in the way war events are misreported in the media by each side.

3.3.3. Dissociation

Dissociation refers to the extreme cognitive mechanism that results in splitting or dissociating the conscious mind from the intensely distressing event. This it does by compartmentalising or repressing the traumatic events into the unconsciousness. Dissociation can be manifested as complete amnesia for the traumatic event or changes in the level of awareness. Dissociation is a defensive response to abnormally severe stress such as torture. But in normal circumstances, frequent resort to defense mechanisms can be maladaptive, as it becomes a learned response to situations that may only be mildly threatening and results in avoidance and poor enactment rather than dealing realistically with the problem. Somatization or conversion is a similar psychological or hysterical mechanism where the psychic distress is 'converted' into a physical symptom like chest pain, headache, or fainting attacks.

3.3.4. Intrusion

The activation of defensive mechanism like denial, avoidance, distortion and dissociation usually accompanied by psychic numbing may initially protect the individual against being overwhelmed by the traumatic experience and the associated affective distress. But in time, the repressed memory of the traumatic event will try to re-enter consciousness,

so that the individual can eventually come to terms with the experience and integrate it into existing schema. If these memories produce intense distress they may not be recalled voluntarily, but rather tend to intrude into consciousness as images or appear in dreams. This would appear to be a cognitive mechanism whereby the traumatic material and the accompanying affect are re-introduced and re-experienced gradually, in small tolerable doses, so that the individual learns to cope at his or her own pace. When the individual fails to recover and adapt through these defensive mechanisms, the cycle of avoidance, psychic numbing and then intrusion phenomena, accompanying distressing affect of anxiety and its physical concomitants of a hyper-aroused state can result in Post-Traumatic Stress Disorder (PTSD).

3.3.5. Accurate appraisal

Accurate appraisal is the healthy form of information processing characterised by accurate perception of what has happened, realistic appraisal of the situation in terms of the persons and circumstances involved, correct assessment about casualty and an effective schema(plan) for enactment. The person who can accurately appraise the nature of the traumatic event is more likely to augment stimuli; actively scan the scene, engage in search of new or necessary information for solving the problem and persist in such attempts. The outcome of this form of cognitive functioning is the ability to act competently in terms of personal needs, available resources and demands of the situation (Wilson, 1988).

3.4. Behaviour

The actual behaviour exhibited in the face of trauma is the outcome of the above mentioned variables and mechanisms, especially the cognitive schema for enactment. Behaviourists would insist that apart from instinctively reacting in a primitive way to conditioned fear(fight or flight), an individual will do what had worked before and for what there had been re-enforcement: or, not do what has been negatively re-enforced. For example, during bombing raids and military operations people instinctively ran for safety to public institutions like temples and schools as they were instructed to do. But when these very 'sanctuaries' were bombed or cordoned off and searched with people being detained or shot, they no longer sought refuge in temples and schools automatically.

3.4.1. Maladaptive Behaviour

When the emotional, cognitive and neuro-physiological responses are overwhelming, for example severe panic, psychic numbing or dissociation, there may ensue a state of paralysis of action or confused behaviour. But in general people cope appropriately, especially if their psycho-physiological responses have been healthy and balanced.

The coping strategies can be oriented towards problem solving by active, goal directed behaviour. In contrast, in expressive coping, the individual may exhibit such emotions as anger, rage, fear, whining and complaining, or helplessness, and indulge in acting out behaviour. In general, negative or palliative coping strategies are safety oriented, defensive operations to reduce the impact of the traumatic event and emotional arousal by negative cognitive re-structuring or re-appraisal; and behaviour characterised by ostrich like denial, avoidance, non-involvement or escape.

3.4.2. Adaptive Behaviour

Positive or resilient coping involves affective balance, accurate appraisal, effective and alternative schemas for enactment, responsible and flexible behaviour. A sense of mastery over events, an internal locus of control, strong ideological commitment and substantial capacity to meet difficult and challenging situations characterises resiliency or 'hardiness' (Wilson, 1988).

Powerful human attachments; drive to survive and will to live; support from family and friends, identification models offered by good leadership, action and thoughts geared to mastery; the shutting out or closing off of terrifying feelings, and the reliance on hope and prayer all seem to assist with coping and may correlate with adaptive behaviour directed towards survival(Raphael, 1986).

4. Post-Stress Response

Following Professor Wilson's interactional model (Table 1) it can be noted that the nature and intensity of the stressor interacts with the personality characteristics of the individual to produce the immediate psycho-physiological reactions. These initial responses determine how the individual will eventually react or adapt to the stressful event.

Traumatic stress refers to unusually severe or catastrophic environmental events, so

traumatising as to produce significant distress in nearly all people. "Although people vary in resiliency, areas of vulnerability and available supports, those subjected to enough stress may be expected to show some stress response"(Horowitz, 1986).

Horowitz (1986) and others who have studied traumatised individuals in different settings have found a common pattern of response to a wide variety of stressors (Wilson,1988), with some individual variation depending on particular emphasis or pattern of manifestation. Horowitz's flow chart (Table 1) can be seen as the final common pathway for all forms of severe stress responses. Pathological intensification at any of the stages of the normal stress response due to severity or duration of stress, or personal vulnerability can cause mental disorders (Table 1).

4.1. Impact

The impact of the event produces the immediate psychological reactions already discussed. Where the individual is overwhelmed by the traumatic experience, pathological responses such as the Acute Stress Reaction (WHO, 1992) can result. The person is dazed or stunned and exhibits confused behaviour. Affecting 20-25% of the people (Raphael, 1986) after a severe traumatic event, the reaction is transient, resolving within a few hours, especially if the individual is removed from the stressful environment. The constriction of consciousness, cognition and affect (numbing) is a potential defense mechanism to protect the vulnerable individual against imminent emotional collapse.

4.2. Outcry

In the next sequence of response to severe stress is the stage of outcry, which has more pervasive manifestations of ongoing emotional reactions. Thus, the predominant mood may be one of fear, sadness or hostility. Pathological reactions include Panic Disorders (subsequent panic attacks can be triggered by a stimuli resembling or symbolically linked to the traumatic event); Hysterical Dissociative states (fugue, amnesia) and Conversion phenomena (aphonia, stupor); and Reactive Psychosis. Initial panic and anxiety may develop into subsequent Phobia for anything resembling the traumatic event and avoidance behaviour. Hysterical or conversion reactions can be seen as defensive mechanisms to reduce the intensely distressing affect by their dissociating (banishing) the traumatic event from consciousness or 'converting' the distress into a bodily symptom. Reactive psychosis has been explained as an escape (into madness) mechanism from intolerable reality for which each one has a different threshold. The form it (i.e. the break with reality) takes may depend on individual susceptibility and intrinsic mode of reaction.

4.3. Denial

In the phase of denial (Table 1) there is cognitive denial of the implications of the stressful life event, emotional numbness and behavioural avoidance. These are believed to be defensive manoeuvres to protect the individual from being overwhelmed by the impact of the traumatic event. Thus, there may be perceptual daze, selective inattention, defense mechanisms like denial, dissociation, distortion, lack of emotional responsiveness, blunting or benumbing, and withdrawal or avoidance. Emotional blunting and withdrawal or irritability may alter patterns of interaction with support systems, affecting family life, friendships, and work relationships. Members of the support network may not understand this change in the person's relationships and so withdraw, reducing the person's support just when he or she most needs it (Horowitz, 1986). Pathological reactions could include Dissociation (amnesia, fugue); Phobic Avoidance; Abuse of Alcohol or Drugs (as a means to reducing the anxiety and distress engendered by drowning or numbing the senses and feelings); and Depression.

4.4. Intrusion

In the intrusive phase, the trauma is re-experienced as intrusive repetition in thought, emotion, and/or behaviour. Mental images in any sensory modality(visual, auditory, olfactory but particularly visual) may intrude unbidden into consciousness. These vivid imageries often provoke intense anxiety, panic and other distressing affect. Commonly, the trauma is re-experienced at night in dreams as nightmares causing markedly disturbed sleep. Usually, these dreams entail a sense of powerlessness and helplessness, of being trapped and unable to escape, of being passive as the traumatic event is re-enacted again and again. Scenes of death and mutilation (death images) of loved ones, encirclement by armies and helicopters sweeping in, may be repeated nightly. The person may wake up screaming in terror, drenched in sweat and trembling all over. Torture victims may dread going to sleep and try to keep awake because of the terrifying experience these dreams bring back. Day time intrusive phenomena like flashback of particular scenes, feeling of recurrence of the event, behavioural re-enactments or aggressive outbursts, impulsive action or irritable reactions can occur. The re-experience of the traumatic event re-evokes anxiety and produces excessive alertness, difficulty in concentration, hypervigilance, hypersensitivity to stimuli particularly to sound, startle reactions, and hyperarousal of the autonomic nervous system.

Abnormal or pathological reactions of the intrusive phase are the common Anxiety Neurosis. The tendency to compulsive repetition of the traumatic image can lead to

Obsessive-Compulsive Neurosis. The sudden, unbidden and obsessive intrusion of traumatic imagery associated with or without disturbing affect and often a subjective resistance or attempt to inhibit control or modulate the intrusion to prevent being flooded by emotion is the essence of the phase and unique feature of the Stress Response Syndrome. Individuals may construct highly predictable, structured and ordered activities or rituals to defend against anxiety (Wilson, 1988) or resort to Phobic Avoidance of stimuli or situations that remind the individual of the traumatic event. Hysterical Excitement and other Acting Out Behaviour can result from the excessive and distressing emotions generated by the intrusive phase.

4.5. Working Through

In the next stage, which may follow after several phases of denial and intrusion have been repeated where cognitive and emotional processing have occurred, the traumatic experience is worked through, the emotional reactions mastered and the new situation assimilated and given meaning. Finally, the traumatic event is accepted as part of past history, the processing completed with closure of the event. Pathological obstruction or incomplete processing may have long lasting effects on life. Thus, children may regress to an earlier psychological stage, losing control over their sphincters(i.e. enuresis), losing their speech or exhibit demanding and other 'infantile' behaviour. Their future development can also be significantly impaired. Permanent personality or character distortions, particularly in adolescents who are especially vulnerable due to their being at the impressionistic stage in life when identity is being established, can lead to such conditions as Delinquency and Anti-Social Personality. Another permanent reaction is in experienced combatants who have seen many battles. They are often adolescents who had joined the movement very young and been exposed to massive trauma where they have witnessed gruesome deaths and mutilating injuries too many of their comrades or had themselves been badly injured. They had frequently been involved in atrocities, having been responsible for many cruel deaths through torture. They show very disturbed aggressive outbursts when they re-experience traumatic events. Death scenes and battles repeatedly overwhelm them in the form of flashbacks and vivid hallucinations. During these periods they completely lose control over themselves becoming very violent and destructive. We have called this Malignant PTSD (Somasundaram, 1994) after Rosenbeck (1985), referred to in the literature as Complex PTSD, or Disorders of Extreme Stress not Otherwise Specified (DESNOS) and found in the DSM-IV under the PTSD Associated Features disorders (APA, 1994, ICD-10 F62.0) Enduring personality changes after catastrophic experiences (WHO, 1992), and cPTSD in ICD 11, a condition very difficult to treat.

Motivational changes due to repeated experiences of devastation, helplessness and powerlessness in the face of overwhelming stress can lead to amotivation and apathy, or despair, loss of hope and purpose in life, and suicidal ideation. Chronic unresolved psychological problems can manifest as Psychosomatic Illness with multiple somatic complaints. Alternatively, when stress is successfully overcome and mastered, positive changes in motivation and personality with resilient coping styles, greater ego strength and self-actualising behaviour can result.

5. Mental Disorders

As already discussed, pathological intensification at any of the stages of the normal stress response can produce mental disorders like PTSD, Anxiety and Depression (Table 1). Of particular importance in traumatization is PTSD.

5.1. Post-Traumatic Stress Disorder (PTSD)

According to Horowitz (1986) the phasic alternation between the denial and intrusive phases, until the traumatic experience is worked through and mastered, is fundamental to the stress response syndrome and, in a pathological degree, to PTSD. He sees severe stress as something that destroys the equilibrium of the inner schemata of the self and the world. Serious traumatic events shatter a person's idea of reality. Such overwhelming events cannot be immediately accepted or integrated in conscious awareness due to the risk of psychological breakdown. As such the details of the events are denied or repressed to penetrate deep into the unconscious where they leave an imprint. They have to be slowly assimilated and the inner models of the world that have sustained the person must now be changed to accord with the new situation. Such revisions take time. The new information must be processed, interpreted and integrated. For example, news of the sudden death of a loved one would be incongruent with the current world picture of the bereaved that included not only wishes and hopes but also habits, routine, roles and self-images that involved the deceased in mutual and intimate relationships. The need to change these mental 'schematas' and the recognition of the loss can evoke unpleasant emotions such as fear, anxiety, sadness and anger. If these emotional responses increase beyond the limits of toleration, the results may be distraught, overwhelmed states of mind. To avoid entry into such states of mind, therefore, controls are activated that will inhibit or modulate the amount of new information allowed in. Defensive manoeuvres will distort, dissociate, deny or repress the information.

This is the state of denial, emotional benumbing and avoidance. But eventually the traumatic event has to be processed and integrated into the inner mental schema or models, if the person is to adapt and continue his life. For this to happen, the traumatic event will have to be introduced back in awareness, perhaps in tolerable doses so that gradual assimilation can take place. This could be as intrusive images of the event, memories or reminders. It could also come back as dreams in sleep. This would be the intrusive phase. But, re-introduction of the memory of what happened can again set off unpleasant emotional reactions, so that the person may again shut down and go into the denial phase. Since the event has to be eventually accepted, another intrusive phase will follow, until what has happened and its implications are matched with inner models, cognitive schemas are revised, worked through and integrated. There is thus 'compulsive repetition' of the new information (the traumatic event) or representations of it in forms of images until the information is digested and assimilated.

This would entail the event being re-appraised as being non-threatening or conforming to inner models or else, the inner schemata must be changed to match the new circumstances(i.e. the traumatic event is recognised in all its implications and accepted in reality). A new world picture may have to be reconstructed from the shattered past.

At any given time, different aspects of a stress event will be at different stages and levels of processing: the degree, effectiveness and type of controls; the modulation of inhibitions and facilitatory processes; and variation in the entry and the emergence from the phases of denial and intrusion in their sequence, emphasis and termination; all of which can cause a wide range of symptomatology in different individuals. Individuals also respond in unique ways due in part to their past history and experience, their present socio-cultural context and personal meaning of the event, as well as their habitual or inherited style of defense and coping. In some individuals, powerful defensive mechanisms may block the intrusive phase for a long period(e.g. six months) until the individual feels safe and relaxes the controls which, often coupled with some perceptual reminder of the event, can then trigger the onset of an intrusive phase of symptoms(Delayed PTSD) (APA, 1993; Horowitz, 1986).

Thus, this model accounts for the phases of intrusion and denial and the eventual resolution of the normal stress response syndrome. Pathological intensification of the process leads to Post-Traumatic Stress Disorder(Table 1).

The World Health Organization's (1992) International Classification of Diseases, 10th revision (ICD 10) used intrusive imagery as the sole symptom for diagnosing PTSD in

traumatised individuals. McFarlane (1988) found that imagery alone is not sufficient to explain the onset of PTSD or its chronic form.

Many researchers have commented on the common association or overlap with other mental disorders like Depression, Anxiety, Alcohol and/or Drug Abuse and Anti-Social Personality (APA, 1993; WHO, 1992). In our experience patients do not usually present with PTSD or complain of its symptoms except in relation to other recognisable conditions like Anxiety, Depression or more commonly, Somatization (Somasundaram,1994).

Green et al(1985) found among war veterans having PTSD, 79% with Depression; 50% Substance Abuse, commonly alcohol; 50% with Anxiety, either Generalised Anxiety or Panic Disorder; and 14% with Anti-Social Personality. Sierless et al (1983) reported that among combat veterans with PTSD, 73% gave a history of Depression, 64% had severe Anxiety and 12% had Anti-Social Personality. Detail description of mental disorders following the traumatic experiences of war are given in the chapters to follow.

The differentiation between normal and pathological stress response (the 'D in the PTSD) remains problematic. As Horowtiz (1986), the originator of the PTSD concept, himself comments, "the differences between common routes of response to serious life events and the pathological intensification of each phase, which leads, in some instances to the diagnosis of a mental disorder such as post-traumatic stress disorder is not clear and to a large extent a matter of degree and, to some of personal as well as social value judgement and labelling".

Admittedly, clinicians, researchers and mental health workers do find (PTSD) diagnosis potentially useful and it does allow for a focus, something to "get a handle on". Undoubtedly the PTSD concept has broken new ground for traumatic stress studies and given us a framework to work with, particularly in helping survivors of disasters. Essentially PTSD is a psycho-dynamic concept, describing intra-psychic mechanisms and thus useful for theoretical understanding of stress response syndromes.

Questions have been raised about using the PTSD diagnostic category in non-western cultures(Marsella et al, 1992; Bracken et al, 1995). Most patients do not complain of PTSD (Kinzie et al, 1990). Nevertheless, we do find in the present war situation many individuals coming for medical treatment with somatic complaints who on investigation are found to have PTSD, and the root cause of their symptoms and distress would also appear to be the trauma experience. But they may not identify the link. As already mentioned, we have found PTSD in a wide variety of trauma victims including torture survivors (see Chapter 5, 6 & 7), although there can be differences in the significance of

the various criteria. For example survivor guilt is not that important or prevalent as in Judeo-Christian cultures. The emotions of shame, blame (outward) and mistrust may be more relevant. These observations have clinical implications for assessment and psychotherapy (Somasundaram, 1997).

A meta-criticism of trauma diagnosis is that it tends to medicalize the problem while diverting attention from the socio-economic and political causes (Mestronic, 1985; Young, 1980; Punamaki, 1989), in our case ethnocentric and nationalistic constructions of reality that give rise to war. On the contrary, identification of PTSD helps the therapist to understand and treat the patient, helping them to come to terms with what has happened and accept the quite 'normal' responses(Marsella et al, 1992). The assessment also helps to identify those who will benefit from special care and treatment to alleviate their individual suffering. The recognition of their suffering itself goes a long way in reassuring and supporting them.

Moreover, PTSD serves as a useful instrument to describe the effects of atrocities perpetuated on civilians. Thus, PTSD becomes an internationally recognised means to draw attention to the plight of civilians, and in the long term to create social awareness and mobilize support for affected populations. Yet, social justice for the victims of war may continue to be an elusive dream.

Narrow medical models are quite inadequate to express the full extent of the mental agony and reactions to war. A descriptive narration of psychological reactions that is to follow, then becomes a way of revealing the effects of war. Transcribed in the language of the mind and body, this history will bring out what conventional accounts of war fail to mention. In the final analysis it is a testimony to the suffering caused by war.

REFERENCE FOR CHAPTER 4

1. Allodi, F. (1980). The Psychiatric Effects of Political Persecution and Torture in Children and Families of Victims. Canada's Mental Health, 28:8-10.
2. Amnesty International (1986). Sri Lanka Disappearances. Al Index: ASA37/08/86. London.
3. Andreason, N. (1985). Posttraumatic Stress Disorder in Comprehensive Textbook of Psychiatry IV (eds. Kaplan, A.I., Preddman, A.M. & Sodock, E.T.), Williams & Willkins, Baltimore, USA.

4. Bracken, P.J., Giller, J. E. & Summerfield, D. (1995). Psychological responses to war and atrocity: the limitations of current concepts. Social Science & Medicine, 40, 1073-1082.

5. Breyer,U. (1988). Living in a Vacuum. Psychological Problems of Refugees and Asylum Seekers. in Refugees-The Trauma of Exile, Ed. Miseace, B., Martinus Nijhoff Publishers, Switzerland.

6. Bodman, F. (1941). War Conditions and the Mental Health of the Child. British Medical Jeurnal, 11:486-8. Quoted by Lyons, H.A. (1971). Psychiatric sequelae in the Belfast Riots, British Journal of Psychiatry, 118, 265-73.

7. Bowlby, J. (1980). Loss: Sadness and Depression (Attachment and Loss, Vol 3) Hegath Press, London.

8. Brett, E.A. & Ostreff, R. (1985). Imagery and Posttraumatic Stress Disorder: An Overview. American Journal of Psychiatry, 142:4.417-424.

9. Caplan (1971). Home from the War, New Requblic, Jan 30.1971. Page 1.

10. Children's Rehabilitation Center (1986). Psychological Help to Child Victims of Political Armed Conflict. CRC, Philippines.

11. Cohn, J., Helzer, K.L.M., Stenerin, B., Denielsn, L., Kech, L., Thogersen, S. & Aalund, O. (1985). Repercussions of Torture, A Study of Chilean Refugee Children in Denmark. The Lancet, Aug 24, 1985. UK.

12. Coleman, J.C. (1975). Abnormal Psychology and Modern life. D.B. Toraporevela Sons & Co., Bombay.

13. Curran, P.S. (1988). Psychiatric Aspects of Terrorist Violence: Northern Ireland 1963-1997. British Journal of Psychiatry.

14. Department of Community Medicine (1995). III MBBS Reseach Project, Faculty of Medicine, University of Jaffna, Jaffna.

15. Durkheim, E. (1951). Suicide, Translated by J.A. Spaulding Simpson. Free Press Illinois.

16. Eisenbruch, M. (1991). From Post-Traumatic Stress Disorder to cultural bereavement: Diagnosis of Southeast Asian Refugees. Social Science and Medicine, 33 (6), 673-680.

17. Fraser, R.M. (1971). The Cost of Commotion: an Analysis of the Psychiatric Sequelae of the 1969 Belfast riots. British Journal of Psychiatry, 115, 257-64.

18. Erikson, K.T. (1976). Loss of Communality at Buffalo Creek. American Journal of Psychiatry, 135:3.30-305.

19. Green, B.L., Lindy, J.B. & Grace, M.C. (1985). Posttraumatic Stress Disorder, towards DSM IV. Journal of Nervous and Mental Disease, 173:7, 406-411.

20. Rees, L.W. (1975). Stress, Distress and Disease. Presidential Address to the Royal College of Psychiatrists (9.7.1975). Reported in British Journal of Psychiatry (1976), 128:3-18.

21. Richman, H., Kanji, N. & Zinkin, P. (1988). Report on Psychological Effects of War on Children in Mozambique, Save the Children Fund, London.

22. Horowitz, M.J. (1986). Stress Response Syndromes, Jason Aronson Lnc., U.S. also see Horowitz, M.J, Wilner, N., Kaltrieder, N. & Alvarez, W. (1980). Signs and Symptoms of Posttraumatic Stress Disorder, Archives of General Psychiatry, 37:85-92.

23. Kardiner, A. & Spiege, I.H. (1941). War Stress and Neurotic illness, Paul, B., Hober, London.

24. Kinston, W. & Rosser, R. (1974). Disaster: Effects on Mental and Physical State. Journal of Psychosomatic Research, 18:437-56.

25. Lacey, J.I. (1959). Psychophysiological Approaches to the evaluation of Psychotherapeutic Process and outcome, in Research in Psychotherapy by Rubinstein, E.A. & Parloff, M.B. (Eds.) American Psychological Association, Washington DC.

26. Lewis, A. (1942). Incidence of Neurosis in England Under War Conditions. Lancet, Aug 15, 1942. 175-185.

27. Lyons, H.A. (1971). Psychiatric Sequelae of the Belfast Riots, British Journal of Psychiatry, II 8, 265-73.

28. Lyons, H.A. (1972). Depressive Illness and Aggression in Belfast. British Medical Journal, February, 5, 1972.

29. Magarian, G.J. (1982). Hyperventilation Syndromes: Infrequently recognized common expressions of anxiety and stress. Medicine, Vol 61 No. 4, pp.219-233.

30. Marsella, A.L., Fredman, M.J. and Spain E.H.A. (1992). Selective review of the literature on ethnocultural aspects of PTSD, PTSD Research Quarterly, 3.1.1992.

31. Mcfarlane, A.C. (1988). The Aetiology of Post-Traumatic stress Disorders Following a Natural Disaster. British Journal of Psychiatry, 152,116-121. See also Mcfarlane A.C. (1989). The Aetiology of Post-Traumatic Morbidity. Predisposing, Precipitating and Precipitating Factors. British Journal of Psychiatry, 154:221-228.

32. Mestrovic, S.C.A. (1985). Sociological Conceptualization of Trauma. Social Science Medicine, 21,835.

33. Merers, C.S. (1940). Shell Shock in France 1914-18. Cambridge University press, Cambridge

34. Mollica, R.F., Donelan, K., Tor, S., Lavelle, J., Eleas, C., Frankel, M., Bennett, D. & Blendon, R.J. (1990). Repatriation and Disability: A Community Study of Health, Mental Health and Social Functioning of the Khmer Residents of Site Two. Volume 1. Harvard Program in Refugee Trauma, USA.

35. Mott, P.W. (1919). War Neuroses and Shell Shock. Oxford Medical Publications, London.

36. Natchinarkinian, C.S. (1994). Current Pattern of health Care and Resource Allocation. In Victims of War in Sri Lanka-A Quest for Health Consensus. eds. Arulanantham, K., Ratneswaran, S. & Sreeharan, N., Medical Institute of Tamils, London.

37. Orner, E.J. (1988). Traumatic Stress Reactions in Falklands War Veterans. Paper Presented at the First European Conference on Traumatic Stress Studies, Lincoln, England.

38. Ortaann, J., Genefke, I.K., Jakobson., Gunder, I. (1987). Rehabilitation of Torture Victims: An Interdisciplinary Treatment Model. American of Social Psychiatrty, VII,4.

39. Nasr, S., Racy, J., Flaherty, J.A. (1983). Psychiatric Effects of the Civil War in Lebanon. Psychiatric Journal of the University of Ottawa, 8:4, 208-212.

40. Patrick, H.A. & Patrick, W.K. (1981). Cyclone'78 in Sri Lanka-Mental Health Trail. British Journal of Psychiatry, 138:210-216.

41. Punamaki, R. (1989). Political Violence and Mental Health. International Journal of Mental Health, 17:3.

42. Put, W., van de (1997). Cambodia and Trauma: Coping with the past and the future for individuals and society, In preparation.

43. Rosenhock. R. (1985). The Malignant Post-Vietnam Stress Syndreme.

44. American Journal of Orthopsychiatry, 55:2, 319-32.

45. Rosenbeck, R. (1986). Impact of Posttraumatic Stress Disorder of World War II on the Next Generation. the Journal of Nervous and Mental Disease, 174:5, 319-27.

46. Shore, J.B., Tatum, E.L. & Volllmer, W.M. (1986). Psychiatric Reactions to Disaster: The Mount St. Helen Experience. American Journal of Psychiatry, 143:5.

47. Sierles, F.S., Chen, J.J., Robert, E.M. & Taylor, M.A. (1983). Posttraumatic Stress Disorder and Concurrent Psychiatric Illness: A Preliminary Report. American Journal of Psychiatry, 140:9,1177-9.

48. Sims, A.C.P. (1983). Neurosis in Society. Macmillan Press Ltd., London.

49. Sims, A.C.P., White, A.C. & Murphy, T. (1979). Aftermath Neurosis: Psychological Squelae of the Birmingham Bombings in Victims not Seriously injured. Medical, Science & Law, Vol 19 No. 2.

50. Sivarajah, N. (1993). Nutritional Status of the Children in Jaffna. Department of Community Medicine, University of Jaffna.

51. Slye, H. (1976). The Stress of Life. McGraw Hill New York.

52. Somsundaram, D.J. (1997). Treatment of Massive Trauma due to War. Advances in Psychiatric Treatment, In press.

53. Somasundaram, D.J. & Sivayokan, S. (1994). War Trauma in a civilian population. British Journal of Psychiatry, 156, 524-527.

54. Somasundaram, D.J. (1996). Post-traumatic responses to aerial bombing. Social Science & Medicine, 42(11), 1465-1471.

55. Sommer, K.E. & Genefke, I.K. (1986). Psychotherapy for Victims of Torture. British Journal of Psychiatry, 149:323-29.

56. Sreeharan, N. (1984). Psychiatric illness and the general physician in developing countries. Tropical Doctor, 14,55.

57. Summerfield, D. (1996). The Impact of War and Atrocity on Civilian Populations: Basic Principles for NGO Interventions and a critique of Psychosocial Trauma Projects. Relief and Rehabilitation Network, Network paper 14. London: Overseas Development Institute.

58. Tan, Eng-Seeng, Simous, C. (1973). Psychiatric Squelae to a Civil Disturbance. British Journal of Psychhiatry, 122,57-63.

59. Tennent, C., Couston. C., & Dent, O. (1986). Clinical Psychiatric illness in Prisoners of war of the Japanese Forty Years after Release. Psychological Medicine, 16:833-39.

60. Terr, L.C. (1981). Forbidden Games. Posttraumatic Child's Play. Journal of the American Academy of Child Psychiatry, 20:241-60.

61. Trautman, E.C. (1964). Fear and Panic in Nazi Concentration Camps: A Biosocial Evaluation of the Chronic Anxiety Syndrome. International Journal of Social Psychiatry, 10:134-41.

62. Trimble, M.R. (1981). Post-Traumatic Neurosis, John Wiley & Sons. Cholchester, UK.

63. UNESCO (1949). Translation of L'Enfance, Victim de la Guer, unetude de a Situation Europeenne. par le docteur Therese Porose, Paris, PP ll-12, (ICRC-1972).

64. Watson, I.P.B., Hoffman, I. & Wilson, G.V. (1988). The Neuropsychiatry of Posttraumatic Stress Disorder. British Journal of Psychiatry, 152:162-73.

65. Walker, J. (1981). The Psychological Problems of Vietnam Veterans. Journal of American Medical Association (JAMA), 246:781-82.

66. Wilson, J.P. (1988). Trauma, Transformation, and Healing. Bruner Masel, New York. see also Wilson, J.P. (1988). Combat Trauma in War Veterans, First European Conference on Traumatic Stress Studies, Aug-Sept, 1988, Lincoln, England.

67. World Health Organization (1992). The ICD-10 Classification of Mental and Behavioural Disorders. Geneva: WHO.

68. Young, A. (1980). The Discourse on Stress and the Reproduction of Conventional Knowledge. Social Science & Medicine, 14.133.1980.

Grief

Look at the atrocities,
What happened to my friend,
What can I do?
How can I offer comfort...
Shall I speak of the mother,
Who carried a child in her womb for ten months,
Only to lose it in an instant?
Or, shall I speak of the father,
Who lost his love and affection?
Shall I speak of how his life,
Shattered like a sparrow's nest?
Or shall I say how a shell's deafening blast
Stole his voice forever?
Shall I speak of how his life turned dark?
Or shall I say how a shell's deafening blast
Stole his voice forever?
He has cried so much,
That now his eyes hold no more tears.
At an age to run and play,
He now lies still.

A hellish life,
He walks through these tortures.
In his heart,
The roots of sorrow are growing,
The torment in his life,
Is an endless pain.

For the sake of being "Tamil,"
This is the price he was made to pay.
Each day, he thinks this way.
The destruction suffered by every Tamil,
Has defeated and subdued his heart.
Will light ever come?
To his life...!

-Pic by Dr. S. Sivathas

-Child Soldier
(Sivathas, S.)
(வானைக் காட்டுங்கள், சிறகு விரிக்க
Vannai Kaaddunkal, Siraku Virikka)
(Translated by Subeasharan Kulasegaram)

CHAPTER 5

PSYCHIATRIC SEQUELAE TO A CHRONIC CIVIL WAR

Introduction

Following the 1983 racial riots, a situation of chronic civil war gradually developed in the North and East of Sri Lanka. There had been increasing discrimination and repression by the state against minority Tamils with growing defiance and militancy among the Tamil youth. The state responded with progressive militarization of the North and East. Youth were detained and tortured. Several attacks of army personal took place. Reprisal civilian massacres followed. The guerrilla ambush at Thirunelvely in July 1983 was a prelude to the racial riots and the ethnic war that followed.

The psychological sequalae to the war described in this chapter is primarily the response to the trauma of war but also the result of deeper conflicts. For people were caught in a rapidly changing social situation where perceptions and consciousness had to be revised and recreated, by force if necessary. A whole new reality had to be constructed where people are willing to go to war and suffer the consequences.

The moderate Tamil leadership had fomented a Tamil nationalism as a reaction to the Sinhala Buddhist consciousness aroused by the Sinhala leadership. The imposition of polarised ethnic consciousness had served the politicians to rise to power. As this was contrary to the existing public reality where a mutual interdependence and co-existence was the rule; force and violence was needed to effect the transformation. The prevailing socio-economic discontent and frustration provided the fuel for the construction of a new reality.

To bring about a change in the people's perceptions and construct a new reality, first the Sri Lankan State had to be divested of its authority in the Tamil mind. The increasing discriminatory polices of the State and the unleashing of state terror cornered the Tamils into an increasingly polarized position. Despite the obvious repressive actions of the State, many Tamils, particularly the elder generation found it difficult to alter their obedience. The competing constructions and demands were themselves extremely stressful and left many confused as to their loyalties. The death, destruction and trauma

of war compelled the Tamils to change their minds and to deconstruct the established system. Among the Tamils, the young militants and eventually the Tigers took over the reins of power. The State and the Tamil militants became locked into a mutually reinforcing violent spiral to construct the new reality. The separatist war was the outward manifestation of the struggle to establish a permanent ethnic polarity and associated loyalties. The psychological fall out of this violent struggle is a record of the traumatic effect on the mind and body of the common people caught between the two forces.

Secondly the Tamil moderate political leadership was discredited and debunked (with the active connivance of the 'Sinhalized' State). Some were killed, others were forced to flee or submit in silence to the new dispensation. Finally, the Tigers asserted themselves as the sole power by eliminating other aspirants and groups. The internecine warfare and the violence which turned inwards caused a greater impact on the local population than the direct war with the Sri Lankan State. The psychological trauma of the internal conflict went much deeper and was felt more keenly. As a result, the psychological reactions were more common and more severe.

Conventional accounts of historical events and war are often narrow descriptions of military battles, the victories and loses, and the politics involved. The people themselves and their agony are quietly forgotten.

The psychological consequences of the gradually worsening civil war in Northern Sri Lanka was only slowly realized by mental health workers, who did not really possess the appropriate knowledge, training or facilities to tackle post-traumatic problems on such a large scale. In fact, it was the insistent inquiries and demand for relief and information that first sounded the alarm and brought to our notice the extent of the developing problems. The first public seminar on the subject was organized by the Valikamam North Citizen's Committee in 1987 during the brief peace accord. The public interest and the increasing number of patients seeking treatment for war induced mental disorders prompted the acquisition of the necessary knowledge, the recording of case histories and the development, through experience, of methods for treating trauma victims. A recent summary of this development of treatment methods is given in the *Advances in Psychiatric Treatment (Somasundaram, 1997).*

Elsewhere in the world too, it is only in recent times that knowledge about post-trauma conditions became established. The category **Post-Traumatic Stress Disorders (PTSD)** came into use only after 1980 when it was first introduced into the American Diagnostic and Statistical Manual, third edition (American Psychiatric Association, 1986). The World Health Organization (1993) had included PTSD in the tenth revision of the

International Classification of Diseases (ICD-10) in 1990. Much of the understanding about the psychopathology of war and PTSD in particular has arisen out of the research on American Vietnam War veterans.

The shortcomings in the PTSD diagnostic category to adequately describe the full effects of war was discussed in the previous chapter. Another problem commonly encountered by medically trained psychiatrists is that many of the psychological reactions to war do not fall into recognized, neat 'disease' categories. But their training and professional competence lay in diagnosing by well-established clinical methods and treating along accepted lines. At times, this was the only stable bearing, a resort to familiar, comfortable terms in the face of uncertainty, powerlessness, impotence and fear created by the horrendous tales of the victims of war. Often those responsible, the perpetuators of the violence were all around in a belligerent mood. The anger and criticism against the culprits had to be stifled while the helpless victims was labelled as mentally sick and treated. Perhaps this was the only constructive option under the prevailing circumstances. With treatment, traumatized individuals did recover their mental balance to face life again and sort out some of their basic problems themselves. Whenever possible, victim were directed to sources of help for relief, rehabilitation, recompensation and recording of grievances. At times, some difficulties were taken up with the authorities in a diplomatic, cautious way, such as the erroneous detention (and torture) of psychiatric patients. The issue of special identity cards to psychiatric cases reduced the number of unnecessary executions of mental patients due to their suspicious and abnormal behaviour. But as a whole the medical profession has remained silent in spite of blatant violation of human rights by all sides and are in a way guilty of passive acquiescence. One form of protest is by testimony and this work is an attempt to record the ravages of war on the common people through their psychological reactions.

Due to the aforementioned restraints, the case histories were recorded under conventional diagnostic categories (ICD-9) and treatment carried out along usual medical lines. The available psychiatric services, the professional training and public expectations demanded this approach in dealing with patients. Thus, much of the observations and analysis remained within a rigid medical framework. To work within the existing structures and facilities, to treat and care for patients using available means seemed the only alternative under the prevailing situation. But in the very unconventional and pathological conditions obtaining under war, language and models begin to fail, becoming inadequate to convey the real nature of the unfolding human tragedy. At least, if a sense of the suffering can be communicated by the conventional methods adopted here, the efforts will be worth while.

Psychodynamically war is a form of severe stress that can cause temporary personality decompensation, even in previously stable personalities, leading to **Transient Stress Reactions.** The decompensation can be **Acute** or sudden as in the case of an individual exposed to an overwhelming experience of death and destruction; or it may be **Chronic** and gradual as in then case of a person who has been subjected to being a refugee or living under conditions of constant but unpredictable shelling. Usually the individual shows good recoverability once the stress situation is over, although in some cases there is residual damage to the personality and an increased vulnerability to stress. In the case of individual who were marginally adjusted to begin with, especially vulnerable or who were predisposed to mental illness, the war stress may precipitate more serious psychopathology, neurotic or psychotic illness. While in others, stress may lead to adaptation and provide the impetus for personality development and increased stress tolerance.

Recent work by Horowitz (1986) and others with victims who have been exposed to severe stress has developed the concept of **Stress Response Syndrome.** A pathological intensification of this basic normal response is postulated to produce the Post-Traumatic Stress Disorder (PTSD) and other mental disorders (see Chapter 4). Common symptoms include anxiety, exaggerated startle response, difficulty in concentrating, memory impairment, recurrent nightmares, social and emotional withdrawal, instability, autonomic hypersensitivity and depressive symptoms (Andreasen,1985). In addition to PTSD, pathological intensification of the basic stress response to severe psychological trauma can produce various psychiatric disorders (Horowitz,1986). Common mental disorders produced by severe stress are **General Anxiety Disorder, Panic Attacks, Phobias, Depression, Alcohol and Drug Abuse, Reactive Psychosis and Personality Disorders** (Horowitz,1986). The reaction pattern to stress are more towards the neurotic end of the spectrum, occurring in otherwise healthy and normal individuals though serious psychotic illness can be precipitated in those predisposed by hereditary, previous traumatic experience or having a vulnerable personality. It is not possible to predict what form the reaction to stress will take in a particular individual, though the pre-morbid personality, habitual reaction patterns to stress, family and past history of mental illness, cognitive and emotional coping styles and the personal meaning, impact and severity of stress in the unique life situation of the individual are good indicators.

The present study reported here is an attempt to show the wide variety of psychological reactions to the severe stress of war by selecting illustrative case histories from those who came for treatment. The psychiatric facilities available in Northern Sri Lanka are limited to daily outpatient clinics at the Teaching Hospital, Jaffna; the District Hospital,

Tellipallai; and the Base Hospital, Point Pedro. Inpatient care is restricted to 60 beds at the District Hospital, Tellipallai, and 40 beds at the Base Hospital, Point Pedro. These represent the only psychiatric services currently available in the region. Some patients from the Eastern province also seek treatment here. This chapter analyses and records the psychological sequelae to the civil war as it presented itself to the author, working in the University Psychiatric Unit at Jaffna and Tellipallai.

Method

Patients seen at the psychiatric out-patient clinics and those admitted to the ward from July, 1983 to July, 1987 formed the subject matter of the study.[1] Representative case histories were selected to illustrate the range of psychiatric illnesses that were caused or precipitated by the prevailing war situation. Although the current situation has affected the whole local population including the mentally ill in one way or another, the sample is chosen from those for whom it played a central role in their illness. Experience gained from general clinics held at refugee camps and some general observations of the period as a whole are also included. In general the diagnosis categories from the WHO-ICD-9 (WHO, 1978) were used for diagnosis and forms the basic structure for the presentation of illustrative case histories. In addition, surveys of the general and specific populations to study the effects of the war years are summarised at the end of the chapter.

Results (Case Histories)

Transient Stress Reactions

The degree of stress in the catchment population (1,300,000) can be assessed indirectly by considering **Table 1 & 2,** which show that the brunt of the war has fallen on the civilian population. **Table 1** reflects the stress of a chronic war situation between 1983 and 1987, while **Table 2** shows the stress of an acute military operation in May and June of 1987, the so-called 'Operation Liberation'. The next chapter deals with the stress of the Indian intervention, from October to December 1987.

[1] A few cases receiving the diagnosis of PTSD after 1990, when the region returned to the civil war situation as before, have also been included as it is felt that this completes the picture of the types of reaction to war. This diagnosis was not made prior to 1990 in the all of Sri Lanka (and is still not made in much of Sri Lanka) due to lack of knowledge and experience. Person's with traumatic reactions would have been diagnosed as Anxiety, Depression or mistaken for a somatic illness. The author was fortunate to obtain a Commonwealth Scholarship for Post-Graduate training at the University of Leeds in 1989, where the current work and literature on trauma was made available to him.

TABLE. 1 STRESS FACTORS IN NORTH AND EAST SRILANKA

(1981-87)

Stress Factors	Year	Month	Numbers	SOURCE*
DEATHS (due to ethnic violence)				
Tamils Total	1981-1987	Up to July	16,994	T.R.R.O
	1981-1982	Jan-Dec	840	H.H.R
	1983	Jan-Dec	1,380	H.H.R
	1984	Jan-Dec	3,670	H.H.R
	1985	Jan-Dec	3,301	H.H.R
	1986	Jan-Dec	2,935	H.H.R
Sinhalese & others (whole Island)	1984-1987	Jan-Dec	2,803	H.H.R
Combatants				
Security Forces	1980-1987	Up to July	1022	Rattwatte, Deputy Minister, in Parliament (9.2.96)
Militants (LTTE)	1987	Up to Aug, 87	689	Govt. of Sri Lanka (Elanadu, 13.9.87)
Missing & disappearance	1985	Jan- Dec	631	LTTE (Uthayan, 28.8.87)
	1986	Jan- Dec	529	H.H.R
Injuries (Admission to Hospital)	1987	Jan- July	199	H.H.R
	1986	Jan-Dec	550	T.R.R.O
Refugees	1987	Jan-July	2103	H.H.R
Internal				
In Camps	1987	July 15th	3168	H.H.R
Outside Camps	1987	July 15th	1,10,680	T.R.R.O
External (Abroad)			2,26,465	T.R.R.O
India	1987	Up to July	1,50,000	Govt. of India Observe (16.5.87) estimated
Other (Europe, Canada,	1987		50,000	
Australia, US, etc.)	1987		25,000	
	Total		**5,62,145**	
Arrests	1985	Jan- Dec	10,068	H.H.R
	1986	Jan- Dec	36,667	H.H.R
	1987	Jan- Dec	16,905	H.H.R
	1986	Jan- DEC	20,336	H.H.R
Released	1987	Jan-Dec	4,936	H.H.R
Damage to Property	1987	July to July	Rs. 60,000 million	Minister of Finance

* Reliable statistics were difficult to come by during this period. Sources quoted include the Refugee and Rehabilitation Organization (T.R.R.O) and Home for Human Rights (H.H.R) which are Non-Governmental Organizations (NGO's) Functioning in the North and East. Information was mainly obtained through citizen committees of the area usually in the form of affidavits from those affected. The T.R.R.O is headed by a respected academician, Prof. K.Sivathamby of the University of Jaffna and the H.H.R by Mr. Xavier, Attorney-at-Law. Newspaper reports are much less reliable. Liberation Tigers of Tamil Eelam (L.T.T.E.) were the main militant group.

-Complied By V. Kamalanathan, Alaveddyy Citizen Committee

TABLE. 2 OPERATION LIBERATION, VADAMARACHCHI AREA

(MAY-JUNE, 1987)

Stress Factors	Year	Month / Period	Numbers	Sources
Deaths				
Civilians				
Tamils	1987	May- June	600	T.R.R.O
Sinhalese	---	---	---	
Combatants				
Sri Lankan Army	1987	May to June	92	H.R.R
Militants	---	Not Available	---	
Missing and Disappearance	1987	May-June	23	H.R.R
Injuries	1987	May- June	229	T.R.R.O
Arrests	1987	May-June	9183	H.R.R
Released	1987	May to June	3005	H.H.R

-Complied By L. Dwight, Social Worker

Apart from the deaths and destruction, the war was characterised by a large number of refugees. The number of refugees in 1987, estimated at 562,145 forms 25% of the total population of the North and East (2,084,660). In medical relief clinics held at refugee camps, the majority of cases were found to suffer from skin conditions (scabies), gastrointestinal disturbances, (diarrhoea, peptic ulcer), upper respiratory tract infections, and Transient Stress Reactions, Reactive Depression, Anxiety and Somatization. The psychological reactions manifested with somatic symptoms of which the following were common: Headache, dizziness, dyspnoea, palpitation, chest pain, backache, numbness of the extremities, dyspepsia and other multiple complaints for which no obvious organic causes could be found. On questioning, sleep disturbances with nightmares, irritability, loss of appetite, and fear were elicited. Many reported dreams of returning to their original home and of activities associated with living there. Due to lack of awareness of the psychological antecedents of their condition, many 'somatized' the stress of being displaced through bodily symptoms. This type of Transient Stress Reactions usually showed spontaneous recovery with the removal of the stress or readjustment and adaptation to the situation by the individual. In some cases, psychological stress was increased by physical complications such as abortions, which were found to have an increased incidence, particularly among fleeing refugees (Theivendran,1987), or mutilation and physical handicap arising from, for example, the loss of a limb (Manoharan & Gnanakumar,1988). Sudden overwhelming stress is known to produce a more acute, dramatic reaction and bring out covert psychopathology:

[2] In Oct-Nov, 1995, the whole population of the Valigamam area in the Jaffna peninsula, estimated variously at 500,000, were displaced within a short period on the sudden orders of the LTTE.

Mrs. T. aged 65 years, was admitted to the Psychiatric Unit in a state of excitement. The history was that she had been normal up to 10 days back when she had been travelling by the boat 'Kummuthini' from Delft in May, 1985 when it had been stopped by Navy personnel and all aboard were cut up with swords and knives. She had seen her son and close kinsmen cut to death in front of her and herself received serious cut injuries. She was treated at the Neurosurgical (NSU) Unit at Jaffna Hospital for 10 days. Concussion or head injury had been ruled out, though she had scalp injuries and diminution of vision. During this time, she was confused and restless and had to be constantly sedated and confined to a room. On discharge her wounds had healed but her mental condition remained disturbed. Later, she was admitted to the Psychiatric Unit in an extreme state of agitation. She was highly suicidal-attempting to run and jump into a well. She was disheveled, shouting and crying in waves, repeating the names of those who had died. She was disoriented in regard to place and time, though she appeared to know her relations who had brought her. Due to the agitation and restlessness, she was immediately sedated and then put on Amitriptyline with Chlorpromazine. She appeared to have calmed down while in the ward but continued to get attacks of restless agitation and suicidal behaviour; though with decreasing frequency. She continued to be disoriented and confused in her general behaviour. Although she showed improvement and was now manageable, the relations discharged her early as they felt that she would settle down in her old home environment in Delft. She is reported to have improved gradually over the months and is able to do work and look after herself, though mild confusion symptoms and diminution of vision remain. It is possible that she already had an early dementia which was made overt by the stress.

Senile confusional states have been reported to increase during war time (Lewis, 1942)

Post Traumatic Stress Disorder (PTSD)

As described in chapter 4, PTSD often follows the experiencing of an extraordinarily traumatic event such as those that occur in war. Essentially PTSD is characterised by re-experiencing the traumatic event through intrusive memories, images or dreams associated with cognitive, emotional and physical distress. Usually, the organism puts up some barriers or limits to being overwhelmed by the event by such defense mechanism as denial or benumbing. It is hypothesised that by re-introducing the traumatic event in smaller, tolerable doses in the form of memories, images or dreams, the organism can work through the trauma and eventually accept and integrate the event into his or

her self and world view (schema). But in some severe trauma victims (such as torture survivors), this may not be possible and chronic conditions with permanent scarring of the mind may result. In our clinical experience we found that the Post-Traumatic Stress Syndrome was invariably associated with other psychiatric disorders, commonly Anxiety and Depression as the following case demonstrates:

Mr. S.R 21 year old, is a student at the University, who came for treatment to the University Medical Centre with complaints of continuous severe headache, giddiness, loss of concentration and musculo-skeletal pain. On mental state examination, he was found to be suffering from severe Anxiety and Depression. Apparently he had been detained twice at various police army and navy camps in Trincomalee and Boosa for a total of over eight months during which he had been systematically tortured. These included being crowded into small rooms with large number of other detainees, stripped naked; kicked and beaten unconscious with boots, iron belts, batons and wooden poles, knotted wires, gunbutts, and S-lon pipes on the head, face, finger joints, shoulders, hips, and knees, hung upside down and in a seated position for long periods: being deprived of food and water or made to 'eat' blood-stained clothes, chilies and lick his own urine. As a result of torture he often had bleeding lips and swollen face or both legs became so swollen & painful that he could not walk & had to be dragged by other detainees. On being released he had joined the University but found it difficult to concentrate or study. Repeated re-enactments of the torture experience as intrusive images with associated feelings of panic (dryness in the mouth, sweating, terror, palpitation, giddiness-he often lost consciousness in describing his experiences) were frequent. These images and memories were particularly triggered off by scenes or stimuli resembling or reminding him of his earlier experiences. For example, the barbed wire at the university, the white electrical wire connecting the fan; certain foods (such as bread and dhal); times such as 2 p.m. when they normally were given food at Boosa or at dawn when they were taken out for their ablutions; on anniversaries of his arrest; in situations of army activity such as round-ups, check points, fighting, tension, gunfire or shelling.

He actively tried to avoid such stimuli, events or reminders but despite all his efforts at resistance, these memories and images repeatedly intruded causing severe emotional upheaval (mainly anxiety). He used to have very disturbed sleep, getting up screaming in the night in sheer terror, awakening everybody in the house. He had become chronically depressed with a deep painful sorrow, feeling of loneliness, a benumbed or paralysed feeling, loss of hope in the future, the thought that he had reached the end, with ideas of suicide. A feeling of fear and insecurity was with him all the time with a tendency to

get angry at the smallest thing, sometimes becoming very violent, breaking things. He had problems of socialising or mixing with other university students, even having difficulties with his own family. But for all this he had developed a strong sense of social service, wanting to help others and be of use to society. He had donated blood three times, he had gradually recovered with time, treatment and counselling but when events or situations resembling his earlier arrest or experience occurred the symptoms become worse, his state regressing to the old anxiety and depression with repeated memories and images of the torture with night terrors.

Anxiety Disorder

Anxiety Disorder is basically a fear reaction that has become incapacitating. As fear was the prevalent emotion during this time, Anxiety states were very common and could be considered almost 'normal' under the circumstances. Patients reported intense apprehension, fear or even terror, feeling of impending doom or death and were found to be tense, edgy, irritable, vigilant and easily startled. Dyspnoea, palpitation, chest pain, choking sensation, difficulty in swallowing, sweating, tremor and other classical somatic symptoms of anxiety were common. Some reported panic attacks during shelling, bombing, gunfire, or on seeing the army. Subsequent panic attacks were triggered by stimuli resembling the original stressor-like loud bangs, or green uniforms. Many had sleep disturbances like difficulty in falling asleep, interrupted sleep, anxiety dreams where they see themselves being injured, killed or attacked but unable to escape, night terrors, and fitful sleep with fatigue on awakening. Optimum anxiety may have been lifesaving in many cases, driving them to seek safety while phobias would have influenced them to avoid potentially dangerous situations. But in some individuals the anxiety was incapacitating, interfering with their normal day to day functioning and they were helped considerably by treatment. Relaxation techniques like yoga were quite useful for long term management of anxiety while medication was useful in the short term.

Patients with previous history of Angina Pectoris developed anginal pain during war-induced anxiety attacks, some even suffered a Myocardial Infraction. Many who presented themselves to the out-patients clinic requesting medical certificates (MC) for absence from work were found to be having signs and symptoms of Phobic Anxiety. Usually, the patient had come from the North and East and due to a traumatic incident there, was unable to go back to work. Typically, they reported fear and apprehension on thinking of going back, together with sweating, tremor, insomnia and constant worry

about getting back to work. But they were not willing to accept that they had a mental condition and only wanted an "MC"

Others developed Phobic Anxiety about going to work when their place of work was affected by military activity.

Dr. (Mrs) S., aged 28 years, was working in a district hospital. The area around the hospital had come under heavy shelling and helicopter strafing, and the people around the hospital had evacuated to safer places. The hospital had been hit while she was on night duty. She had become very anxious about coming to work and described mounting fear when walking to the hospital. While at work, she was in constant state of tension and fear and was anxious to leave the hospital. Night duty had become extremely difficult, with only a skeleton staff available and the constant sound of explosions surrounding the hospital. Even thinking of coming in for night duty, used to cause palpitation, tremor, sweating and loose motions. As she was pregnant, she was worried about her unborn child and feared an abortion. As the situation deteriorated, she became depressed at times, and dreaded continuing going to work. As other M.O's had reported sick, she requested an MC till the situation settled.

Several patients who had undergone torture presented with severe Anxiety states.

Mr. S., aged 24 was a computer salesman working in the Middle East who had come to get registered for marriage. According to his history, on his way back at the Katunayake Airport, after having cleared customs and immigration and while waiting in the departure lounge, he was 'taken in' by plain clothes policemen (CID) unknown to his relations, who assumed that he had boarded the plane and departed. He was then taken to the '4th floor' (notorious floor in Police headquarters, Colombo where torture takes place) and questioned for three days without sleep, proper food and frequent assaults. He was later removed to Welikade where he was put in with 70 other detainees in a room. While there, batches of five prisoners were taken to a room, each in turn was made to sit in a chair and a head band with a wire connected to a machine was applied around the temples. A little later the prisoner was seen to have convulsions. This 'treatment' was repeated for each, while the others watched. Altogether he said that he received four such treatments. At the end of three weeks he was again taken to the airport to the waiting lounge allowed to board the plane and proceed as before. On reaching Bombay he felt too ill to proceed and was warded there and treated mainly for the contusions and bruising due to assault. Later feeling apprehensive and anxious, he had decided to

return to his home and presented at the consultant practice with frank Anxiety Neurosis. He was treated with anxiolytics and antidepressants and had improved gradually. On follow up he had migrated to Canada. It is well known that Electro-Convulsive Therapy (ECT) can make Anxiety States worse or even precipitate it in a predisposed individual.

Hysteria or Conversion Disorder

Hysterical behaviour may be an unconscious coping mechanism to under conditions of extreme stress and can be lifesaving. The adoption of a 'sick role' where the primary gain from hysterical behaviour was prevention of further assault, is reported:

Mrs. T., was a middle-aged lady with an only child, a girl aged 10 years, living in a boarding. Her husband had died 7 years earlier of Myocardial Infraction. She was a diagnosed case of Hysterical Neurosis with Depression and had been admitted to the ward several times. She had been living alone in her home when the army had surrounded the area. The other residents had fled the area but she had refused to leave her house. From the history that we were able to piece together after she recovered, the army had entered her house and dragged her by her hair and thrown her into a truck.... while the truck was taking them back to the camp she had fallen out but they had again thrown her back. She had been screaming the whole time. At the camp, she had been confined to a room and assaulted. She had begged them to shoot her. Subsequently, perhaps realizing that something was wrong, they had offered to take her to Colombo for treatment but she had refused. The 10 year old daughter, on learning of her mother's arrest, had written to several authorities including the President explaining her mother's condition which received wide publicity. She was released a few days later. On admission to our Unit the next day, she appeared to be in a semi-comatose condition and had to be carried to the hospital. She was dishevelled and her clothes were in disarray. If anyone touched her, she screamed and at other times was groaning. On examination there were a few contusions with abrasive marks across her back. Routine X-rays revealed no fractures and no serious internal injuries were detected. Based on our previous experience with the patient, a regime of behavioural therapy to reinforce a return to healthy behaviour was instituted with analgesics, anti-depressants and anxiolytics. She rapidly improved in the ward environment and was discharged in one week. It was apparent that her adoption of a sick role and histrionic behaviour had saved her from further torture.

Interestingly, this type of behaviour didn't work with the militants.

A mother had two teen age daughters. Her husband had been arrested in Colombo, but she had managed to get him released by crying, begging and generally creating a scene at the police station. Her husband had since gone abroad. When her elder daughter joined the militants, she had kept going to the camp regularly begging to see her daughter, crying, wailing, falling on the ground and beating her head. However, the female militants were unimpressed. They made sarcastic remarks, treated her with contempt, even beat her and generally ignored her antics outside the camp, refusing to show her daughter to her. Apparently there were several mothers in this condition outside the camp. In time the mother came to our clinic with Depression and Hysterical Neurosis. We were able to arrange for her daughter to visit the mother regularly.

Grief Reaction

Grief Reactions were very common and could be considered a phenomenon of the times in view of the large number of civilians deaths. Due to the suddenness and the psychologically traumatising circumstances surrounding these unnatural (and unnecessary) deaths of loved ones, there was an increase in the more severe Grief Reactions and several with atypical features were also presented to our unit.

Mrs. J. aged 30 years was an assistant medical practitioner who had recently been married to an engineer. While travelling by passenger coach, Mr. J had been shot at an army check point and subsequently died 2 days later. His wife developed a severe form of typical Grief Reaction with waves of crying spells and acute sorrow. She had strong guilt feeling for not immediately rushing to the husband's side and helping in his treatment. Further she felt guilty that she had not stayed with her husband much longer after marriage so that she could have conceived before his death. She developed extreme social withdrawal and was unable to leave her room and meet people. Her symptoms have been very incapacitating and had prevented her return to work. Her acceptance of her husband's deaths and working through of her grief had been delayed, and her progress was very slow.

M. was a well built young militant of 20 years. His close buddy had been killed while experimenting with explosives. He was inconsolable and reacted violently and aggressively. It took five of his colleagues to hold him down. He was determined to attack the army camp single-handedly with his SMG. He was swinging his arms and legs about violently and trying to get at his gun. He was brought with the greatest difficulty and had to be sedated with Haloperidol 20mg IV. Gradually his violent 'Acting-Out Behaviour' subsided over a few days with heavy sedation and he was able to work through his grief and accept the death of his friend.

Mrs. S.K. aged 34 years, had been suffering from various neurotic complaints for over 10 years. Two weeks prior to admission she had been told that her favourite brother had died in action while attacking the army. She refused to accept this as she hadn't seen the body. She firmly believed that her brother was alive. Her chronic neurotic complaints become worse and she complained of insomnia, loss of appetite, chest pain, palpitations, weakness, feelings of fear and tension with sweating and tremors, attacks of abdominal pain and diarrhoea, and giddiness. At times she misidentified others as her brother and thought that he had come back. She was put on Imipramine and Chlordiazepoxide, and bereavement counselling was given in the ward. Gradually she was made to talk about her brother and accept his death. These sessions led to crying spells and expressions of her grief which had a therapeutic effect.

Miss P. aged 18 years and a good student, had seen her brother, to whom she was very attached, shot and killed by army personnel in their home compound. The vision of him lying in a pool of blood used to repeatedly recur causing a restless agitated behaviour with crying spells. At times she used to become extremely paranoid that the army was coming to kill them or that her father was going to hand her over to the army. She was put on anti-depressants but didn't show any improvement. Later, characteristic delusions of persecution and third-person auditory hallucinations were elicited, and a diagnosis of Schizophreniform Reactions was made. She improved dramatically on phenothiazine and ECT.

Miss. S., aged 25 years, was working at a tutory. One day while at home she had received news that her brother had been killed in an internecine war between the groups. She has been very close to this younger brother from childhood and had looked after his welfare at home. On hearing the news the patient had run to a well and jumped in. She was

immediately pulled out and taken to the local hospital. Apparently there was no organic injury, though she appeared to be unconscious and had 'fits' from time to time. On transfer to our unit, no physical injury (head injury) or respiratory problems were noted. As her level of consciousness and pattern of fits were characteristically functional, a provisional diagnosis of Hysterical Conversion Neurosis was made. She was abreacted and under sedation made to work through the traumatising event. The ward milieu was adjusted to reinforce healthy behaviour. She made a quick recovery but developed a typical Grief Reaction. Bereavement counselling was given and she was encouraged to work through her grief. She made an uneventful recovery but was readmitted one month later with attempted suicide on the occasion of the 31st day of her brother's death.

Reactive Depression

A large number of patients with Depression secondary to the prevailing situation presented to the outpatient clinic and for in-ward treatment. The Reactive type of Depression is known to be brought on by any type of loss. In addition to the grief reactions, some of which merged into true Depressive illness due to loss of loved ones; loss of a bodily part such as a limb; loss of house and property due to shelling or bombardment; loss of employment and other sources of income, for example among daily wage earners, farmers and fishermen; loss of dignity and humiliation due to detention, assault or torture; and loss of virginity and chastity due to rape were also some causes for the development of the illness. In some cases, wives presented with Reactive Depression when their husbands were taken for questioning and assaulted or, conversely, husbands developed loss of libido and other depressive symptoms when their wives had been raped by the army.

Many patients who presented with various psychosomatic complaints to general practitioners or at outpatients departments (OPD) were suffering from what has been called 'vital' Depression (Sims, 1988). Vital feelings are the localisation of depression in a bodily organ, perhaps as pain in the head, chest or elsewhere, and is similar to 'Somatization' of emotions common in our culture. Depressive symptoms were also commonly associated with other disorders like Anxiety. Psychotic or Endogenous type of Depression was precipitated in patients who had past histories of such episodes or a positive family history.

Depression is common among those who are permanently disabled, such as those who suddenly lose their eyesight, hearing or the use of a limb. Manoharan and Ganakumaran

(1988) found that among those fitted with an artificial 'Jaipur Foot' in Jaffna, 50% had lost their limbs due to traumatic amputation following war related injuries such as shell blast, land mines and gun shot. Of these, 40% were severely depressed. They reported suicidal ideas following their handicap, but before receiving an artificial limb. A further 30% were moderately depressed with symptoms like loss of appetite, frequent crying spells and feelings of hopelessness and helplessness. Only 15% said they were happy that they had escaped with their lives. Most reported sympathy and care from the family and society but found this irritating and condescending. The majority were found to stay at home, avoiding social contact. Some reported that they developed an inferiority complex due to such 'humanitarian' concern as being offered a seat in a crowded bus. A young boy who lost his leg refused to go to school because he was afraid of being ridiculed in school. A wife reported that her husband had started neglecting her after she had lost her leg. Earnest Jones (1943) estimated that only 8% of soldiers who lost a leg developed a 'normal' response of resignation and acceptance.

Those who have worked with patients who have lost their limbs reported a variety of psychological reactions. Dr. Nachinarkiniyan, Director, Teaching Hospital, Jaffna, described their feelings; *"Due to the increasing wanton destruction in the last few years on this soil, the number who have lost one of the most important organs, like a leg, has increased notably. It is only natural that a fear that they are lame, disabled, will be ridiculed or ostracised by society rises upon them. In a world full of competition and jealousy, the feeling that to succeed on one leg is difficult may well be true" (Jaipur Foot Programme ,1988) Mr. Ramanathan, an experienced social service officer put it this way, "Those who lose their legs lose hope, become depressed and inactive"* (Jaipur Foot Programme ,1988).

Some of the victims gave graphic accounts of their mental state. Mr. Balasingham, Assistant Government Agent, describes his emotions on losing his leg to a land mine, *"I thought this was the end of my life. I panicked, there was inner turmoil, I cried in time the feeling that I was lame, disabled and handicapped overpowered me. What will be my future? How am I to continue my work? Ambitions were shattered, self-content destroyed, mental state was disturbed. But I am determined to lead a useful life, to do my duty. That is my only hope and goal"*(Jaipur Foot Programme, 1988). Many of the ex-servicemen of the Sri Lankan army who had lost a limb felt dejected, depressed and rejected by the society they had tried to serve. Some were suicidal (Institute for Human Rights, 1996).

Reactive Depression was commonly observed following torture which engender feelings of fear, loss of self-esteem, profound humiliation and ***'learned helplessness'***:

A robust young man of 27 years, Mr.T. who had previously been an energetic fisherman, presented at our clinic with loss of interest, weakness, sleepiness, muscular pain all over the body and symptoms suggestive of peptic ulcer. He had been taken in by the army and sent to Boosa. He had a limp due to childhood polio but a 'doctor' who had examined him had declared that it was due to an old gun shot injury. Thus, he was suspected of being a 'terrorist' and subjected to torture. He had been released a month earlier and had taken treatment from many a doctor for muscular pain and peptic ulcer but without improvement. Mental state examination suggested Reactive Depression and he was treated with Imipramine, supportive psychotherapy and occupational therapy. He was shown gradual improvement on this regime.

Mr. K., was an old man of 57 who had worked as a labourer. He had been taken in by the army and repeatedly assaulted in an attempt to get information about the militants. He was released after a few days but showed listlessness and lack of interest in work. He tended to keep to himself and avoid social contact. His appetite was also poor. Apparently he had a Cerebro-Vascular Accident (CVA) some years back and had dysathria and weakness of the right side. He was put on an anti-depressant and improved gradually.

Mr. G., was a 22 years old healthy, helper in a local militant group. After his group had been proscribed, he had been arrested by the dominant group. According to his history he had been tortured for 2 weeks and detained for 3 months. He had been beaten all over the body with hands, legs, knees, poles, iron rods and stepped on till he lost consciousness. He had been hung by his two thumbs and also upside down by his ankles and beaten on his soles. At various times his face and other parts were swollen, with bleeding from the ear and haemetemesis. Two needles had been driven through his 4th finger. The captives were given one meal and three tumblers of water per day for all their needs, which left them in a continuous state of hunger and thirst. He had been asked to sign a confession but had resisted. Others who had signed had been executed. He now complained of pain all over the body, dyspnoea, backache, difficulty in using his hands, dyspepsia, vertigo and paraesthesiaes. His mother had found him getting up screaming in the nights, drenched with sweat. He felt weak and sleepy and could not participate in much activity. He was socially withdrawn and tended to brood and cry at times. He complained of loss of memory and inability to concentrate. He said that, at times, he used to get an irresistible desire to eat his captors. On examination, physically there was limitation of movement at several joints, particularly the 1st metacarpophalangeal joints, lumbosacral joints and knee joints. There was diminished breath sounds on the

right side of the chest. Mentally there was psychomotor retardation with marked disillusionment. Chest X-ray had been ordered and he was started on analgesics, anti-depressants and psychotherapy. We later learned that he had been killed by the group which had arrested him earlier.

R. is married with two young children. He was transferred to the psychiatric unit from the medical ward at Jaffna G.H with complaints of chest pain, other somatic complaints, insomnia, panic attacks, episodes of loss of consciousness, suicidal ideas and depression with frequent crying spells. He was arrested by the militant group in power at Thandikulam when he was travelling to take up duties at a hospital. He was brought to Jaffna and kept in custody. He was forced to sign a form declaring himself as a traitor to the Tamils after being assaulted. Photos were taken of him with a number hanged on his neck. He stated that he was hit on bony prominence using a sharp flat stick, randomly struck all over the body by being punched and kicked by a group of torturers; kept naked; tied to an iron gate and often kicked in the genital area; asked to drink dirty water mixed with urine; tied to a coconut tree and whipped till he was bleeding and flesh hung from his body; salt water was poured on these wounds; they ripped off the hanging flesh as he screamed. They untied him and asked him to roll in the sand. His wounds became infected with pus. His wounds and injuries were treated with antibiotics in-between the torture sessions. They tied his wrists with a rope and pulled him up by a pulley, leaving him hanging and screaming. In another session, while lying flat, a heavy log was placed across his legs and rolled up to the groin; his penis was placed on a hot iron and twisted. He was beaten on the chest with sticks which resulted in multiple fractures of ribs.

He underwent the following psychological torture:

Kept naked in a small dark cell alone; hearing the screams and moans of other torture victims; kept terrified by being pulled out at any time of the day or night to be tortured, he could not sleep and cringed in fear when the door opened, obsessed by fear of wondering when they would come to get him; he was made to see others tortured: a man who had 80 paper pins pierced into the upper limbs, a man having his nails pulled out by pliers, men kept hanging by the wrist till they died, and men suffocated to death by pouring water over their face continuously. He underwent interrogation both by a friendly and a terrifying torturer.

He was transferred to another camp when he was found not guilty; He developed severe chest pain and was taken to Jaffna G.H. As he was suicidal and depressed, he was transferred to the psychiatric unit.

Psychosomatic disorder

Psychological stress is known to cause physical disorders like eczema, back aches, tension headaches, bronchial asthma, hyperventilation, paroxysmal tachycardia, hypertension, migraine, peptic ulcer, mucous colitis and hyperthyroidism to mention a few. Most of these conditions are treated in the OPD, by general practitioners or physicians and rarely by a psychiatrist. According to a physician working at the Jaffna General Hospital, psychosomatic disorders were very common during the current war period (Nageswaran, personal communication)

Mrs. M., aged 52 years, is a Nursing Officer with a past history of bronchial asthma. She was displaced from her home due to army activity in the area. Subsequently she learned that her house had been flattened by explosives. Her bronchial asthma was exacerbated whenever she heard explosions. Later she also developed urticarial rashes all over the body during bombing and shelling. The rash tended to subside spontaneously within a few hours, once the bombardment stopped.

Mr. K., aged 65 years, was known to be hypertensive, but was not under treatment. On hearing that his son had been killed during the internecine war among the Tamil militant groups during 1986 he went into 'psychological shock' with a dazed, benumbed appearance. Soon after he developed weakness of the left side-a Cerebro Vascular Accident (CVA). After a few days he was brought to the Psychiatric Unit owing to a typical Grief Reaction for which he was treated.

Obsessive-Compulsive Disorders

Obsessive tendencies to rigidity in patterns of behaviour, orderliness, cleanliness, keeping fixed times and pervading sense of insecurity(Sims, 1988) can be increased under stress in those with vulnerable personalities. According to Wilson (1988), the need for safety under threatening situations can *'lead to behaviours designed to defend against anxiety by constructing highly predictable, structured and ordered activities'* (see Chapter 4).Obsessive-compulsive features were found to complicate other disorders, mainly as an accentuation of the pre-morbid personality by the current stress:

Mrs. G., aged 60, was a housewife who had been displaced from her home and was living as a refugee with the author. She was found to be repeatedly sweeping the house over and over again in the same day. At other times she was found to be standing outside the gate gazing into the distance or looking expectantly at those going on the road. Relations had noticed her lack of interest in other activities, found her quiet, withdrawn and very worried. She had crying spells and expressed fear. On examination she had psychomotor retardation, constant worrying about her home and a feeling of general weakness. Reactive Depression was diagnosed and treated with a placebo and supportive psychotherapy. She made a spontaneous recovery on return to her home after the peace accord.

Mr.S.P., aged 62, previously normal. Was a re-employed engineer whose house and property had been completely burnt and destroyed during the July '83 riots in Colombo. He had spartanly rebuilt the house after an year but had installed an elaborate locking system for the windows, doors and gate. Several times each day he used to go around the house checking and rechecking these locks and switching off the lights, but gets irritated when others interfere or question this routine. The ritualistic behaviour and paranoid ideas become more marked with time.

Personality Disorders

Abnormal Personality development in children and personality disorders particularly Anti-Social Personality are well known long term consequences of War (APA, 1986,1994). Anti-Social Personalities were found to be common among Vietnam war veterans(Sierless et al, 1983), as were higher rates of arrest and conviction, particularly among those who had engaged in abusive violence or participated in atrocities during the war (Yager et al, 1984). Increased irritability, poor impulse control and unpredictable explosions of aggressive behaviour have been described frequently in war veterans(Andreason,1985). An addiction to violent behaviour as a means of maintaining a high level of arousal, excitement or thrill found among combat veterans had been called **Malignant PTSD** (Rosenbeck, 1985). An increase in Juvenile Delinquency among children under war conditions has been noted (Lewis, 1942). Paranoid Personality was common among the militants, more marked in the higher ranks, where they showed deep suspicion and intolerance, particularly for rival groups. However, many of the youthful militants initially had a 'soft', amiable personality with altruistic and humanitarian concern for their society. But with time they became hardened and rigid in their thinking, perhaps

due to the brutalising effect of the actions they had to do. Conspicuous among the lower ranks and younger members were stereotyped thinking, use of clichés and stock phrases, standard rhetoric, barely suppressed anger, boastful bravado and suicidal ruminations. They showed marked uneasiness and irritability to changes in routine, alternate views or civilian life patterns. These characteristics are evidence of strict training, indoctrination and brainwashing at that young age.

Other personality deviations among the male members included psychopathy:

Mr.C., aged 22, was a senior member in a militant group. He had been brought by his comrades for suicidal threats. On taking a detailed history, it was found that he was the only son in a family torn by marital strife. The father was an alcoholic, constantly at logger-heads with the son. Recently the father died of Myocardial Infarction soon after receiving a suicide letter from the son (which read *"I will be dead by the time you read this..."). The son showed no guilt or sorrow at his father's death. He had switched from one group to another and was in serious trouble with some of them. He was an alcoholic for several years standing and had left his girlfriend. The picture was that of a Psychopathic Personality and we first withdrew him from alcohol before starting on brief focused psychotherapy. He showed interest in changing his personality but did not return for follow-up.*

Anti-Social or Psychopathic Personalities are characterised by a conspicuous lack of conscience and human sympathy; rejection of social norms; emotional coldness; poor relationships; meaningless, cruel, callous and aggressive behaviour; and poor impulse control(Sims, 1988). Delinquents, aggressive and Psychopathic Personalities may do well in a military set-up, where their energies and excess aggression can be diverted to national ends and their confinement in the army a protection for society.

Hysterical Personality was common among females and children who joined the militant groups. Female members admitted to medical wards during periods of stress, such as when their groups were proscribed and attacked, presented with conversion symptoms like chest pain, dyspnoea, hyperventilation, functional fits, and fainting attacks. They were histrionic in behaviour, attention seeking and seductive, leading to problems with males in the groups. The commoner occurrence of Hysterical Personality among women has been attributed to the socio-political dominance by males and sexism, the females developing the 'sick role' as a means of compensation for their powerlessness or as a way of getting things done when other methods fail. The strong male dominance prevalent in the Tamil society may have influenced the female members to join the movement as

a means of liberation, and later manifesting as hysterical behaviour when they found the same patriarchal structure in the militant organisations. Children presented with headaches, dizziness, fainting spells, or chest pain within a few days or months of joining the militant movement. They were found to have repressed Separation Anxiety for their parents and home, or difficulties in adjusting to the rigors of training and militant life. Many of them had joined the movement on impulse due to relationship problems, difficulties at home, transient frustrations or for the adventure, but soon found the going too tough for them. The unconscious adaptation of a 'sick role' was an honourable way of getting out of an unbearable situation. However, once in, leaving was always difficult. The LTTE had a very strict 'punishment' regime for those who wanted to leave.

Reports of dissatisfaction, indiscipline and suicide in both army personnel and militants may be related to motivation. The reason for joining was primarily economical in the lower ranks of the army, and may not have quite counter-balanced the risk of life and other hardships of war, setting up a classical approach-avoidance conflict. The large number of desertions, running into tens of thousands may be a result of this. Among the militants, initially there was much altruism and dedication to high goals that turned to disillusionment with the incongruous activities they found themselves involved in. Later socio-economic deprivation(caste and poverty), frustrations in education and life; desire for revenge when their kith and kin were directly killed or injured and realistic fears for their fate at the hands of the army were prime motivating factors.

Several cases have been reported since the mid-1980s in which members of the security forces suddenly went out of control, killing men, women, and children in frenzied outbursts. Notable incidents include the Killinochchi railway station killings, the Kumuthini boat massacre, the Chedikulam massacre, the Dollar and Kent Farm incidents, the Kokkadicholai massacre, and the violence in VVT during 1984-85. Similar behaviour had been reported wherever war is being fought. In Vietnam there was the Mai Lai massacre among others. Bosnia and Rwanda are well publicised examples. One wonders whether such behaviour is a natural outcome of what war does to man, besides the training and indoctrination calculated to bring out the beast in him.

The condition of addiction to violence or **Malignant PTSD** was first described by Rosenbeck (1985), *"where they come to feel most alive when they are in a situation of intense conflict or potential danger, and feel bored or depressed in the absence of such a situation. Many were anxious or paranoid in crowds or public places and could get irritated or argumentative in such situations"*. The condition has been described under Disorders of Extreme Stress not Otherwise Specified (DESNOS) and more recently in ICD 11 as

Complex PTSD, characterised by alterations in regulating affective arousal with difficulty in modulating anger, self-destructive and suicidal behaviour and impulsive and risk-taking behaviour. They exhibit chronic characterological changes, including significant alterations in self-perception-marked by persistent guilt and shame, feelings of self-blame, a sense of ineffectiveness, and a belief in being permanently damaged. There is also a tendency to victimize others, along with profound shifts in systems of meaning, such as pervasive despair, hopelessness, and the loss of previously sustaining beliefs (Jong, 1997). The WHO (1992) also includes permanent hostility and distrust.

In children, their personality development can become permanently distorted and deformed due to their experience of violence. A NAMDA report from South Africa states that they "become incapable of imparting trust to their friends and associates and even to their own children once grown up. They may develop smouldering bitterness and resentment and a thirst for revenge which overwhelms them. They may be unable to exercise control over their own feelings and may act out their impulses in anti-social ways (Redd Barna, Oslo). Thus, children participating in violence frequently become dehumanised in the process (Kelman, 1973), developing Anti-Social Personality characteristics. Adolescents are particularly vulnerable during their impressionable, formative period, causing permanent scarring of their developing personality.

R. a 17 year old boy, came with complaints of insomnia, restless behaviour & aggressive outbursts. He had a normal childhood and had joined the militants two years previously. After training, he had taken part in many battles. In the last major battle most of his colleagues had been killed in gruesome ways in front of his eyes and he had himself been injured. After recovering from his injury, he had developed the above symptoms. He said he sometimes heard and saw his colleagues shouting in pain and suffering agonising deaths. He usually lost control at these times.

His response to treatment was poor and sometimes became violent during therapy. Other forms of behaviour, occupational, relaxation and expressive therapies also showed poor responses. In the ward he had broken most of the furniture, equipment, the glass panes, once cutting his hand badly, and assaulted the staff during his violent outbursts. When the severity of re-experiencing subsided with time, a period of rest at home caused re-emergence of the disturbance with difficulties in relating to and adapting to the home situation. At home he frequently had violent outbursts, breaking things in the house, assaulting the family and sometimes running out on the road and beating innocent bystanders. He often tried to commit suicide by jumping into the well or injuring himself.

The family was always watching him to prevent any harm. When the behaviour became excessively uncontrollable the family brought him to the psychiatric ward where he was kept for a few weeks. The behaviour in the ward and response to treatment was no different from the first time. Once he had been admitted to the surgical ward after injuring himself during a suicidal attempt. There he had gone berserk, destroying everything in his path and assaulting many of the staff. He fractured his wrist in the process. He was admitted and discharged several times from the psychiatric ward with no long-term improvement

M., a young army lieutenant was attached to the intelligence unit. They had been responsible for many undercover operations which included planning and implementing civilian killings, sometimes deliberate massacres. He had initially found the work engaging as he felt that all his talents were being used for the best interests of the country. But after one year, he started having doubts. He found the idle conversations with his colleagues more and more difficult to bear. Particular the talk over meals after completing a gruesome operation was extremely disturbing. He started having difficulties in sleeping with nightmares. He felt tense most of the day. He became more irritable, losing his temper over minor incidents. Sometimes, he lost control, becoming violent. This started happening more often and in civil life, with his girlfriend, his family, and even in public where he had assaulted innocent bystanders. His girlfriend left him and he decided to leave the army though the procedure was difficult. He had tried to get help from a psychiatrist and a counsellor but to no avail.

We started him on Amitriptyline and Carbamazepine (which were rapidly tailed off) and then taught him to start practising Ana Pana Sati or mindful breathing. He was not a practising Buddhist but remembered having learnt this method from a monk in a Vihara in his childhood. Gradually, his violent outbursts, irritability and tension began to diminish. He said that he was now more relaxed and conscious, so that he was aware when he was getting irritated and could control his anger early. His sleep went back to normal and his interactions became pleasant. Finding this change in him, the girlfriend came back to him and they were eventually married. He now works privately in a job that he says is very satisfying.

K. a pleasant looking 15 year old boy, came with complaints of insomnia, irrational talk, abnormal behaviour & aggressive outbursts towards camp mates. R. like any other boy had a normal upbringing in a farm in Batticaloa. He had good relations with his family. He joined the militant group at the age of 11 in 1989. He was given extensive training and taught that those who do not support the struggle are his enemies and should be killed. When starting active combat duty the killings at first affected him, but gradually he became obsessed by the need to see blood and got pleasure from brutally killing people. After one attack where he lost many of his comrades, he was shown videos of killed women and children and told that his enemies had done this. This was soon after the outbreak of the second phase of war in June 1990.

This group was then taken to attack an Eastern village inhabited by another ethnic group. He recounts how he killed the inhabitants. He felt no remorse when he described how he held a child by its legs and bashed the head against the wall until the brain matter came out, of how he enjoyed the mother's screams and how he hacked the mother, among others, to death later. He said that they deserved to die. He partook in 4 village massacres. When inactive he felt bored and restless. He longed to go into combat and brutally kill people. He was obsessed with the sight of blood. He became easily irritable and broke out in sudden violent outbursts at the slightest thing. They found it difficult to control him. He felt anger and contempt when he saw people enjoying themselves at temples and wedding festivals.

Treatment of these disturbed adolescents was extremely difficult. They did not respond to high doses of any of the drugs available. The major tranquilizers, anti-depressants, minor tranquillisers and the anti-epileptic, Carbamazepine were all tried. Psychotherapy proved impossible as they were not responsive. Other therapies also showed poor response. When the severity of re-experiencing subsided with time, a period of rest at home caused re-emergence of the disturbance with difficulties in relating to civilian life as was reported frequently in Vietnam War veterans who became misfits in society (Wilson, 1988).

Some of them have shown the florid features of Sadistic Personality or preoccupation with death images and scenes including their own death, a condition described as Necrophilia.

A 23 years old male presented at the psychiatric clinic at the Teaching Hospital Jaffna, with complaints of insomnia, numbness of head and flashbacks of dead friends. He had joined the militant group at the age of 14 and underwent extensive training. As he lost his friends one by one in missions, he became more withdrawn and preoccupied with thoughts of his dead friends. He also led a very tense life during active duty. He developed a hatred towards people whom he was led to believe are traitors and who pass information to his enemies. He caught 3 people whom he considered were informants and tortured them by slowly cutting them to pieces while they screamed. He then threw these pieces on to the nearby road. After this he began to be obsessed by the sight of blood and hearing his victims screaming in pain. He also had nightmares of dead comrades being blown to bits. His insomnia worsened and he began to take Diazepam. He became addicted and started taking up to 40 mg at a time. He introduced this to other boys. He also had a severe headache accompanied by numbness of the head. His drug abuse habit was detected by his superiors who put him on punishment, where he was physically beaten and kept in detention. He is obsessed with the urge to torture and to see blood. When he was asked to draw a picture, he chose a dark red crayon and drew blood drops, a hanging man, a knife stained with blood, a grave and ghosts.

The immense problems of demobilisation and caring for these veterans, and giving them a satisfying, safe role in society and re-integrating them back into community life is one of the immense problems facing us once the war finally comes to an end.

Alcohol and Drug Addiction

Alcoholism and Drug Abuse are common complications of the **"Stress Response Syndrome"** (Horowitz, 1986) and PTSD (APA, 1993). Alcohol and various psychotropic drugs are used in an attempt to reduce the emotional distress caused by the traumatic event, particularly in the intrusive phase with unpleasant memories (Horowitz, 1986). They are believed to work by causing ***'benumbing'*** or emotional anaesthesia, but with continued use there is the risk of developing dependence and addiction. Alcohol has anxiolytic properties and its initial use may be to allay anxiety associated with stress. Several studies have shown an increased incidence of Alcoholism and Drug Abuse under war conditions. Vietnam War veterans were found to have high rates for Alcoholism (Walker & Cavenn, 1982) and Drug Abuse (Sierles, 1983) while those who had participated in atrocities showed greater use of heroin and cannabis (Yager, Laufer & Gallops, 1984). Similarly, Australian World War II veterans showed high rates for Alcohol Abuse and

Dependence (Tennant, Gouston & Dent, 1986). There was a significant increase in Drug Addiction and Alcoholism in the general population following the civil war in Lebanon (Nasr, Pasy & Flaherty, 1983).

There was a concerted effort by the local militant groups to control alcoholism and drug addiction during the war in the North and East of Sri Lanka through propaganda, banning of illicit brewing and sale of 'kasippu' (home brewed illicit liquor) and trafficking in heroin and other drugs. These measures may have been successful to some extent as evidenced by a spate of admission for heroin withdrawal when it became unavailable due to the ban. Some of these youths had picked up the habit abroad, notably in Bombay, Karachi, Germany, Italy and France, where they had migrated during the present crisis and got involved in the drug trade for economical reasons or to collect money for the militants. They then came and passed on the habit on to local friends and associates. Although sniffing was the route of administration commonly employed, a significant number were taking it intravenously (Vincent, 1990). Withdrawal was often difficult, with only a few successfully giving up at the first attempt.

Mr. G., was a middle aged father of two children, who presented himself to our unit for heroin withdrawal. He was found to be in a severely debilitated state, obviously a shell of his old self. He had been involved with the militants from their inception and had been on intimate terms with the old leadership. As he was a skilled mechanic with the ability to manufacture and repair firearms, he had been an important associate. He had been taken in by the police during a routine operation in the early 1980's. They had questioned him and briefly tortured him, including having him place his genitals inside a drawer and then closing it shut. He reported pain and haematuria for several days following the torture. They had released him the same day without realizing who he was. He made good his escape to India that day itself and said that he had just managed to save himself as the security forces had cordoned off and searched his area for him that same night.

In India he had closely associated with the militants, helping them by repairing arms. However, with the development of personality clashes among the leaders, the split into new groups and then the internecine warfare of 1986, he became disillusioned and lost his commitment to the cause. Some of the old stalwarts had been killed, others left to go abroad or start successful businesses. He himself, had become depressed and despondent and started to drink heavily, later taking to the use of heroin. He then drifted, serving some Indian smugglers before becoming involved with the drug trade. He reported that

there was a net-work of Tamil youth who were involved in smuggling heroin to various parts of the world for personal profit and to help the militants. The risks were high but the "pay off" was also high. After some time, he had started running a lucrative 'establishment' catering to foreign tourists in Pondicchery. By this time, he was heavily addicted to heroin and had learned to self-administer it intravenously. He reported that he was not able to be without the drug, even for a few hours, as this brought on the severe withdrawal symptoms with restlessness, irritability, running nose, goose pimples, cramps in the stomach and a intense craving for the drug. Despite his high earnings, he had progressively lost all his money and valuables, even pawning his wife's 'thalikody'. When the Indo-Lankan accord was signed and subsequently refugees were sent back, he resolved to return and start a new life. He was disgusted with his present condition and the predicament of his wife and children. On return he presented himself for withdrawal which was quite difficult due to the degree of addiction and his poor physical condition. Fortunately, his motivation to stop was remarkably high and he made a good recovery. After discharge, he has shown great social motivation in starting an Alcoholic Anonymous (AA) group.

Patients who had become abstinent under treatment relapsed during this period of stress:

Mr. Y., was a middle aged businessman whose drinking had been controlled with regular treatment. But with the onset of the war there was disruption of commercial activity. There was no work and no trade and many of the businessmen used to sit around and drink. He gradually lost control over his drinking and is now drinking heavily.

Suicide

Suicide rates are remarkably constant for each society but show a marked fall during war (Durkheim, 1951). War is said to increase social cohesion against a common enemy and this give meaning to live. However, the drop in suicide rates may be due to war providing an alternate channel for suicidal behaviour (Burvill, 1980) or an opportunity to externalise aggression (Lyons, 1979). Thus, suicide rates in Jaffna have shown the same trend during the war (Fig-1) with a marked fall during periods of intense fighting (Somasundaram & Rajadurai, 1995). Whereas suicide is common among the elderly elsewhere in the world (Durkheim, 1951), a study of suicide in Jaffna showed highest risk in the 25-34 age group (Ganesvaran, Subramaniam & Mahadevan, 1984). The authors

conclude that this phenomenon may be related to ethnic violence and revolt among the youth. Dissanayake and De Silva (1974) found a similar high risk for suicide and attempted suicide among the youth (aged 15-34 years) for Sri Lanka as a whole and attributed it to unemployment and unrest among the youth as manifested in the 1971 JVP insurgency. It is noteworthy that the suicide rate for Sri Lanka as a whole is the highest in the world (see Chapter 1), as it was in Jaffna before the war (Ganeswaran, Subramaniam & Mahadevan, 1984). Attempted suicide in Jaffna is also high among the youth and commonly follows stress (Ganevaran & Rajarajeswaran, 1989).

Mr. H.S., aged 43 years, living in Jaffna town, is an engineer, lecturing at a Technical Institute. He had a diagnosis of Schizo-Affective disorder and was doing well on maintenance treatment. There had been incessant, heavy bombing of Jaffna town for some days. A few hours previous to the suicide attempt he had been seen by his relations to cover his ears with his hands and say, "when will all this bombing stop". Subsequently he had swallowed, as stated by him 300 tablets of Diazepam. He developed neurological complication from Diazepam toxicity but made a gradual recovery.

Mr. G., a young and handsome bank manager was injured by shell fire from the fort during 1986 and succumbed to his injuries two day later. His fiancé committed suicide on hearing of his death.

The psychodynamic explanation describes suicide similar to depression as a form of aggression turned inwards towards the self, whereas war provides an outlet for the aggression to be turned outwards towards a common enemy (Lyons,1979). Burvill (1980) hypothesised that war may provide an alternate opportunity for suicidal behaviour some support for this view comes from clinical observations during the war here. Adolescents in a mental state caused by intense frustration or interpersonal conflict that made them think of suicide and would have led to suicidal attempts in normal times, often said that they would rather join the militants and die in combat where at least their lives would have been honoured on posters (a common method of commemorating dead combatants here). The Director of the only counselling centre in Jaffna, the Association for Health and Counselling or Shantiam, in a seminar for medical officers described the current social ethos as one where adolescents or youth faced with severe family conflict or environmental stress will at times threaten or carry out two possible alternatives-one is suicide and the other, join the militants (Anandarajah, personal communication).

Our study (Somasundaram & Rajadurai, 1995) shows that the drop in suicide rate with war is more marked for males (by 300%) than females (by 180%) and is most marked for the 15-24 age group (from 62.4 to 25.4 per 100,000) than for the 25-34 age group (fig 2). Males in the adolescent age group 15-24 year range are predominantly the majority among those joining the militants. This also is the age group which had the highest suicide rate before the war started.

A unique form of suicide was the use of cyanide capsules by the LTTE militants in the event of imminent capture, ostensibly to avoid giving information under torture. An estimated one third of the LTTE's combat deaths during 1983-1990 owed to suicide. This pattern of suicide is similar to what the sociologist Emilie Durkheim (1951) called altruistic suicide, in which the individual feels so closely identified with a group committed to the cause, that he is willing to sacrifice himself for the greater good. Suicide squads similar to the Japanese Kamikaze were also seen. Death fasts in the Indian tradition, but without even water, may well have been the zenith of self-sacrifice for a cause. If these altruistic suicides are included in the calculation for suicide rates, then Jaffna may well not show the remarkable drop found in the above study.

Psychosis

In a predisposed or vulnerable individual, extreme stress may precipitate psychotic illness, while in others it can cause a transient Psychotic Reaction (Kelman, 1973). Due to the severity of the illness many needed intense treatment.

A brother and sister, Mr. K.L and Miss K.P aged 24 years and 20 years respectively, presented to the Psychiatric Unit within a day of each other, with symptoms suggestive of Schizophrenia. The boy was restless and wandering around aimlessly, violent and aggressive, but at times withdrawn, irrational, with auditory hallucinations and persecutory delusions. The sister also had a similar picture. The change of behaviour is said to have followed immediately after the first bombing attack in their area. The boy made a full recovery on neuroleptics and occupational therapy. The girl needed ECT before she recovered. There was no previous history and no immediate family history. As the acute attack followed a severe stress and both made a full recovery, Acute Psychotic Reaction was diagnosed in both cases.

A.,an 18 years old student had an extroverted personality and was a college prefect, basketball captain, and took a leading part in other sports and extracurricular activities. A good student, he had been keenly preparing for the G.C.E. 'A' level examinations to be held the next month. At that time, the Parents-Students Association met and decided to boycott the examinations in the peninsula to protest the arrest of students and occupation of schools by the army. The relations noticed a change in his behaviour from that time. He became over-talkative, restless, irritable and violent at times. When he was brought to Hospital, five days after the onset, we found him elated with grandiose ideas and plans. He was over-talkative and restless. A diagnosis of Hypomania was made and an eventual high dose of Haloperidol (12mg tds) and Chlorpromazine (100 mg tds) was needed to bring him under control.

Mrs. S., 47 years, was a housewife who had an attack of endogenous depression previously which had been treated. She had been quite normal up to about a month before admission. For the last month her area had been experiencing frequent helicopter strafing and artillery shelling. At times, the army moved through their area and they had to take refuge in a nearby temple. According to the patient this constant moving about and noise of explosions started bothering her and created a state of constant worry and tension. When she presented at the consultant practice, she had psychomotor retardation, diurnal variation in mood, disturbed sleep, anorexia and multiple bodily complaints. She was put on anti-depressants but as she didn't show improvement, she was admitted and given ECT.

R., was an 18 years old militant who was fighting in the battle front and had been subjected to a continuous artillery barrage and aerial bombing. He had seen some of his colleagues killed in gruesome circumstances. After a few days of this he had a complete 'breakdown' with fragmentation and disorganisation of his personality. When he was admitted to Tellipallai he was in a severe state of disorganisation and rational communication was impossible. A severe combat reaction was first suspected, but as he did not improve and developed characteristic Schizophrenic signs and symptoms, a diagnosis of Acute Schizophrenia was made. Despite energetic treatment with neuroleptics and ECT, he continued to have residual symptoms and has been readmitted several times.

In a study on Schizophrenia among Sri Lankan Tamils during war time, the authors concluded: *"The prevailing troubled situation in the area would have influenced some of the findings in our study, notably admissions due to the difficult and hazardous journey to reach the hospital for drugs or admission, sex ratio due to migration of young males, court referrals and pathoplastic effect on the symptomatology such as on persecutory delusions, in addition to environmental stress precipitating the illness"* (Somasundaram, Yoganathan & Ganesvaran, 1993) Persecutory delusions often concerned the police, army and militant groups.

Sociocultural factors and the milieu has a pathoplastic effect on the content of symptoms. Thus, the war played a central role in the clinical picture of nearly all the patients. Many felt that the army were out to capture or kill them and jeeps were coming in the night to take away. Often these fears proved quite realistic and premonitory of what actually happened. Current political issues were commonly mixed up with the main concerns of the patients. We also found that the explanations given for the mechanism of symptoms changed with time in keeping with the situation. First, in the early 1980's, the common explanation for auditory hallucinations was that voices were coming over the radio and telephone, later it was television and recently patients claimed that voices were being conveyed by walkie-talkies or modern communication equipment. One patient claimed that he was being controlled by SAM missiles.

Schizophrenic illness with apathy and indifference to external stimuli can be protective against environmental stress in some cases (Wing,1978). When the Tellipallai Hospital was evacuated to a nearby hospital due to army action in the area, some of the Schizophrenic patients in the psychiatric unit refused to budge and the unit had to function throughout this critical period. They appeared well insulated against all that was going on around them and appeared indifferent to the loud explosions. Their withdrawal into themselves can be a defensive mechanism against external stress.

Due to the disruption of the judicial services during this period, no cases were referred by the normal courts for psychiatric assessment and treatment. Under normal circumstances, the majority of patients referred by courts used to suffer from psychoses, particularly Schizophrenia (Ganesvaran, Somasundaram & Rajarajeswaran,1982).

Some of these unfortunate patients, who should normally have received protection by courts and compulsory treatment by psychiatrists, met with unnatural deaths such as by suicide, homicide or extra-judicial killing by armed men. Some of them in their restless behaviour, wandered around during curfew hours or near army camps, and were arrested or shot. Others by their odd and bizarre behaviour raised the suspicion

of local militant groups and were interrogated by torture and shot when their answers were irrational and unsatisfactory. The Psychiatric Unit later provided identity cards to patients, explaining their condition and the killings were reduced. Not all these patients were suffering from 'functional' psychiatric illness as the following case of organic delirium illustrates.

Mr. T., 62 years old farmer, had been admitted to Tellipallai for abnormal behaviour of a few days duration. When we saw him, he was disoriented and confused with persecutory delusions. There was mild dysathria. In his case history it was revealed that he had been quite normal up to a few days ago when he had started behaving a little oddly and had fallen into a well. Due to the possibility of C.V.A and/or head injury he was immediately transferred to General Hospital, Jaffna for further investigation and management. Apparently in the Jaffna Hospital he had been taken from the ward to the X-ray unit on a trolley, when he suddenly jumped down and 'escaped', probably due to the fear and restlessness that were part of his illness. The next day he was found shot and tied to a lamp post opposite the Kacheri with a sign saying that he was an anti-social element.

By the 1990's when the militants established their own judiciary and police to maintain 'law and order' a system was gradually evolved where suspected psychiatric patients with legal problems could be referred for treatment and report by the police or courts.

Childhood Disorders

Children commonly present with disturbances in emotion and/or behaviour (conduct) when under stress:

Master K.S aged 12 years, was a bright student attending school regularly. His father had gone as a refugee to Germany in 1984. The boy was reported to have talked of his father frequently expressing a hope that he would return soon. The patient's mother was injured by shelling in 1986 and was permanently crippled. For the past three months the child had started behaving abnormally. He easily lost his temper and became violent and aggressive when frustrated. He was reported to throw things into the well, throw stones onto the tiled roof, and attempt to set fire to the house when angry. At school, he used to get fainting attacks and had to return home. He was detected at the school medical inspection and referred to the Psychiatric Clinic. His condition is essentially one of Conduct Disorder due to adverse family circumstances.

Disturbances in sleep with nightmares and night terrors were widely prevalent following traumatic incidents. The reliving of traumatic experience in dreams may serve as a natural abreaction process whereby the child is able to work through and come to terms with the traumatic experience by repeated exposure, which he is unable to face while awake (Bleich, Garb & Kettler,1986):

Mr. R., was a well to do engineer with two sons, aged 2 and 8 years. One night, a local militant group had come to their house and killed the father after assaulting him with chains in front of the children. Subsequently both children used to get up in their sleep screaming in terror and drenched with sweat. A benzodiazepine was prescribed for the night and the children got over their night terrors but any permanent scar on their development was difficult to assess.

Another common occurrence among children were Hysterical Conversion symptoms:

C., was an 11 years old student doing well in school. One day while travelling to school by mini-bus they had been strafed by helicopter. There was immediate panic. The driver stopped the bus and everybody had fled. The child was unable to remember much of the details, but managed to return home. The next morning he was unable to speak. The parents tried various indigenous treatments and eventually brought him to us. In addition to the aphonia, the child looked apprehensive and disturbed with frequent bobbing movements of the head. He was found to be highly sensitive to the sound of helicopters. He was admitted and with an anxiolytic, a regime of behaviour therapy to reinforce gradual return to normal speech was instituted. He was slowly able to talk and was sent on trial leave to attend school. He relapsed on being taken to school and it appeared that he also had developed school phobia. The child was made to attend school from the ward, accompanied by the mother who was asked to stay with him at school. The teacher was requested to ignore any deviant behaviour or aphonia and continue to teach the child. One day the mother left the ward with the child and did not return thereafter, probably owing to the child reverting to normal behaviour.

Children under 5 years with psychiatric problems formed a small proportion of the cases in the clinic (5%) and an even smaller fraction of those (0.8%) admitted to the ward in 1983 (Somasundaram et al,1986). Reluctance to admit children to psychiatric units stem from the absence of facilities, the stigma attached to mental illness and lack of awareness of childhood behavioural disturbances (Malhotra, Inam & Wig , 1977)

The trauma of war appears to have caused considerable problems in children and by the 90's we found an increasing number coming for treatment. For example, children (up to 18 years) formed 12.6% of 1st visits at the outpatient psychiatric clinic at the G.H. Jaffna and 8% of admissions at D.H Tellipallai (functioning in Manipay after displacement) in 1994. Studies of the student population shows that this is just the tip of the iceberg and psychological problems are widely prevalent in the schools up to and including the University (Arunakirinathan et al, 1993; Sivashanmugarajah et al, 1994; Geevathasan et al, 1993). It is significant that the Health Reach Program at McMaster University (1996) did a detailed study of children in the Eastern Province of Sri Lanka, in addition to their studies in Yugoslavia, Palestine and Iraq, and found considerably more war trauma and psychological problems in Tamil (including Muslim) children compared to Sinhalese children.

Two small studies were carried out on 3-6 year olds in the Jaffna Peninsula. One was an in-depth one year observational study of 76 children in the Kokuvil & Kondavil area (just north of Jaffna town) identified as having been exposed to war trauma, out of whom 18 were 3-6 years old (Lakshman & Sivashankar, 1994). In the second, randomly selected 50 pre-school children studying in Montessories in the Vaddukoddai cluster area were studied (Rasiah & Nadarajah, 1994). Common disturbances reported by parents and teachers are shown in **Table 3.**

TABLE. 3 COMMON SYMPTOMS IN PRE SCHOOL CHILDREN (KOKUVIL-KONDAVIL, VADDUKODDAI)

Symptoms	Kokuvil-Kondavil (n=18)	Vaddukoddai (n=50)
Crying	78%	--
Sadness	40%	--
Sleep disturbances	39%	58%
Irritability	44%	82%
Withdrawal from play	39%	30%
Clinging behavior	44%	46%
Phobia of the army or uniformed men	44%	--
Sounds of gunshots	61%	--
Refusal to sleep alone	78%	64%
Listlessness	--	58%
Hyper alertness	--	60%
Aggression	05%	36%
Temper tantrum	--	70%
Symptoms of PTSD	--	22%

An extensive study of the Vaddukoddai cluster schools in conjunction with the Department of Education showed wide prevalence of traumatization among students (43%) and a wide variety of behavioural disturbances reported by parents and teachers(Arunakirinathan et al, 1993). A salient finding was the pervasiveness of indirect stresses such as poverty, displacement etc. A more detailed description will be found in the Dr. A. Sivapathasundram Memorial Lecture on Child Trauma (Somasundaram, 1993). A summary of the commoner symptoms is given in the **Table 4.**

TABLE. 4 COMMON SYMPTOMS IN SCHOOL CHILDREN (VADDUKODAI)

Symptoms	(n=305) Perecentages
Sleep disturbance	77%
Separation anxiety	40%
Hyper alertness	50%
Sadness	43%
Clinging	45%
Withdrawal	25%
Decline in school performance	60%
Irritability	73%
Aggressiveness	46%
Cruelty	30%
Anti-social behaviour	44%
War games	54%
War vocabulary	64%

The last few symptoms of hostility such as anger, aggressiveness, cruelty and indicative of brutalization in the war milieu are very disturbing recent developments. Many of our children have been born during the war and continue to grow up amidst it. They have known no other world.

Adolescents

Adolescence is a critical period of transition to adulthood when childhood developmental stages and identity formation comes to a climax. We have now several studies of youth in Jaffna (Geevathasan et al, 1993; Arunakirnathan et al , 1993) and Killinochchi Districts (Sivashamugarajah, Kalaivany & Somasundaram, 1994), while a study of the new entrants to the Jaffna University has been only completed in the faculty of agriculture (Sivashamugarajah, Kalaivany & Somasundaram, 1994). Common types of war stresses experienced by youth are shown in **Table 5**.

TABLE. 5 WAR STRESS IN ADOLESCENTS

(Percentages)

WAR STRESS	JAFFNA n=200	VADU n=211	CHAVA n=60	MADDU n=48	KILLI n=48	AGRI n=46
Direct war stress:						
Threat to life	9	5	27	20	48	45
Injury	2	3	7	8	10	15
Detention	--	12	7	3	4	13
Torture	--	7	--	3	4	9
War death of relation	16	15	50	23	31	60
Witnessing violence	14	6	47	22	35	32
Indirect War Stress:						
Displacement	56	26	22	32	44	61
Lack of Food	--	19	5	20	15	33
Economic problems	--	38	25	45	48	52
Mean number of stress			2.9	3.3	4.2	5.4

Jaffna- St. Johns College, Chundukuli. and Vembadi Girls College G.C.E. O & A level students
Vaddu- Random sample from 12 Vaddukoddai Schools
Chava- Chavakacheri Hindu College
Killi- Killinochi Mahavidyalaya
Agri- Faculty of Agriculture, University of Jaffna at Killinochi

TABLE. 6 PSYCHO SOCIAL PROBLEMS IN ADOLESCENTES

(Percentages)

Psychosocial Problems	JAFFNA n=200	VADU n=211	CHAVA n=60	MADDU n=60	KILLI n=48	AGRI n=46
PTSD	31	36	18	50	15	44
Somatization	68	--	17	71	44	--
Anxiety	38	38	22	40	40	33
Depression	25	36	30	17	27	44
Hostility	59	33	57	37	63	30
Relationships problems	24	25	50	23	58	30
Alcohol & Drug Abuse	--	--	--	02	19	20
Functional disability	--	33	78	20	54	35
Cognitive Impairment						
Loss of memory	46	28	57	48	65	37
Loss of concentration	33	35	58	55	60	57
Loss of Motivation	--	--	60	35	56	50

The great majority of students had experienced multiple stressors per student: and often the stresses were chronic. The psychosocial sequelae found in adolescent students is given in **Table 6:**

In our culture where education takes on an overriding importance (education related deprivation was one of the original causes of the war), disturbance in regular schooling, tutories and examinations has become a prominent stressor. The future appears bleak with nothing to plan for or look forward to. So much so that the earlier motivation to study, to excel in education and achieve a respectable occupation is slowly being eroded. Militancy or migration becomes an alluring alternative. The symptoms of cognitive impairment are particularly worrying. It would come as no surprise that among Tamils, the overall performance at the national General Certificate Examination (G.C.E.) O' & A' level exams (Dept. of Education, 1993) as well as University admissions has declined in recent years,[3] particularly in Jaffna which once held the pride of top place in educational attainment. There may be complex reasons for this deterioration. As already mentioned, lack of facilities and resources, frequent displacement and disruption, necessity to study by kerosene light (there being no electricity from 1990) and so on have been put forward as causes by the Jaffna University sub-committee on Education (University of Jaffna, 1994). Many of the more intelligent students have also left the area, similar to the brain drain among their elders. One telling fact was that only six students were admitted on the merit list for medicine from Jaffna district in 1993, while this is usually around 36 according to the sub-committee.

Apart from the general surveys of students who show considerable degree of brutalization, there have been individual adolescents with what we have termed Malignant PTSD coming for treatment (vide supra). Some had joined the movement at a very young age and had been exposed to massive trauma-witnessing gruesome deaths and mutilating injuries suffered by many of their comrades, or enduring such injuries themselves. Many still carried unremovable fragments in their heads or bodies, physical reminders of the violence they had survived. They had frequently been involved in atrocities, having been responsible for many cruel deaths and torture. They presented with very disturbed,

[3] For example, admission to the Universities which is based on 'A' level results has shown a drastic fall as far as Tamils are concerned compared to the Sinhalese who have shown an increase. Although this trend has been there from the 70's when standardization and other state policies started, the recent fall is due to directly to the deleterious effect of the war. Thus, Tamil admissions for 1991 was 1194 and 1375 for 1992, but only 697 in 1993, accounting for less than 10% of all admissions. Usually Tamil students secure more admissions through the merit quota (40% of admissions) but this has been most affected. In 1991, 766 Tamil students made it on merit, in 1992 it was 818 but fell to 296 in 1993. The decline is most marked for Jaffna students who usually account for the majority of Tamil admissions. In 1991, 942 were from the Jaffna District, in 1992 it was 922, but fell to 399 in 1993 showing a 60% decline (Chandreseharam, 1996). The GCE 'O' level examination was not held at all in the North in 1995 due to the war.

aggressive outbursts when they re-experienced traumatic events. Death scenes and battles repeatedly overwhelmed them in the form of flashbacks and vivid hallucinations. During these periods they completely lost control over themselves becoming very violent and destructive.

It is likely that exposure of children during their formative years to insecurity, hopelessness, violent deaths of loved ones, as well as other cruel and aggressive action and to the full paraphernalia of war with its' instruments of destruction, will permanently influence their development. Indications of this influence is seen in the plethora of war toys and games that our children are so fond of playing with and in their daily vocabulary (see Table 4). It is a common observation here that under conditions of stress such as bombing and shelling, the younger generation shows much less fear, and flight such as running for cover as do the older generation, and show much more interest in the details of what is going on.

Lyons (1979) concludes his study of civil violence in Northern Ireland with the gloomy prognosis, *"The normal child in the short term enjoys the group activity and excitement, but in the longer term he has learned that violence is an acceptable and successful way of life and this will have a disturbing effect on his personality development in the future".*

Children in war

In a night
of war
pressure-filled
the young ones
grow up.

Across the paths
of their mornings
like delicate birds
are thrown
blood soaked
faceless bodies,
walls crumble
on their spirited laughter
our young are
young no more.

A burst of gunfire
shatters the stillness
of a star-filled sky
destroying the meaning
of children's stories.
make guns
from sticks and logs kill friends
thinking them enemies,
these are the games
our children play.

In a night full of pressure
during war
our young have grown up.

-Sivaramani[1]

[1] Sivaramani committed suicide after burning most of her poems. (https://polity.lk/wp-content/uploads/2024/07 poems-of-sivaramani.pdf)

Gender

An increased vulnerability in women to develop psychiatric problems during war and civil violence has been reported. In London General practices during World War II, women outnumbered men by a ratio of 2:1 in cases of neurotic illness (Lewis, 1942). In Belfast, N. Ireland, a ratio of 3:1 (Female to Male) was found for all psychiatric disorders and significantly the stress of civil violence was the major or contributing factor in all patients (Lyons, 1979).

In Northern Sri Lanka the male to female ratio for admission remained close to 1:1 from before the war until 1986 (Table 7).

TABLE. 7 PSYCHATRIC MALE AND FEMALE ADMISSION
(TELLIPALLAI)
(NUMBERS)

Year	Male ward	Female ward	Sex ratio Male/Female	Sex Ratio Female/Male
1980	488	484	1.00	0.99
1981	472	400	1.18	0.85
1982	689	663	1.03	0.96
1983	623	598	1.04	0.96
1984	644	569	1.13	0.80
1985	622	566	1.09	0.91
1986	607	576	1.05	0.95
1987	395	509	0.77	1.29
1988	589	700	0.84	1.19
1989	590	671	0.87	1.14
1990	533	272*	-	-
1991	537	633	0.84	1.18
1992	595	733	0.81	1.23
1993	576	687	0.83	1.19
Total	7,427+	7,789+	0.95+	1.05+

* 1st and part of 2nd quarter only (hospital was displaced due to war)
\+ excluding 1990

In developing countries of Asia and Africa preponderance of males in the ratio of 1:2 (female to Male) is usual (Ihezue, 1986) while the reverse is true of developed countries (Shepard et al, 1966). As discussed by Prof. Ganesvaran and Rajarajeswaran (1983), the high rate of literacy (85%), may be an important factor influencing sex ratio in Jaffna, leading to an awareness, acceptance and understanding of mental illness in females. It may also reflect the sex ratio of the resident population due to the absence of young males in the age group where mental illness is common (70% of the mentally ill are form the 20-44 year group). Some in this age group left seeking jobs and other opportunities

abroad. It was also this age group that joined the militants, were killed, migrated or left the area out of fear, seeking asylum in foreign countries. It is significant that the army routinely arrests all Tamil men in this age group, even announcing publicly over loud speakers, in areas where there is a cordon and search operation in progress, for all youth/men in this specific age bracket (varying from 15 years upward to 35 years) to assemble at a designated place. Sometimes the whole lot is arrested as when in 1987, during operation liberation, all Tamil youth were shipped south to Boosa army camp. Often, they are detained for long periods on mere suspicion, without judicial processing, tortured and 'disappeared'. At times all the young men were pulled out of their homes, refugee camps, or check points and summarily executed on the spot. Thus, it is no surprise that most of the young men tried to escape the 'Herodian' solution adopted by the Sri Lankan army to crush the militancy. It is also noteworthy that it was the same age group that swelled the ranks of the militants, a vicious cycle where the increasing repressive policies aimed at this age group forced them to join the militants or flee abroad.

For all these reasons the women were left behind to shoulder the responsibility of family, home and keep the society functioning during this critical period (Sivachandran, 1994). While men left their wives and children behind, women did not leave their children or husband to emigrate or flee the area (with few exceptions in cases of Middle East housemaid jobs). They were left to face the trauma of war all alone. They looked after their families single-handedly, filling in for the absent male in what had been up to then, traditional male roles. They rode bicycles in greater numbers, went to the shops, met and argued with authorities, took their children to schools and temples, and generally 'kept the home fires burning' during this crisis in our society. They were thus under considerable stress and more vulnerable to breakdown. The sex ratio of admission tilted even further towards female preponderance as the war continued, due to accentuation of this process (for example by 1991 the ratio of female to male was 1.2:1). In the final analysis this may have been the price women had to pay to save our society from collapse.

Elderly

Although the increase in the elderly population has not been so marked as in the West. we do see an increased number of them coming for treatment -particularly for Acute and Chronic Confusional States and Dementing illness. This can again be traced, as mentioned, to the current situation where the extended and nuclear family support and care is no longer available. Many of the elderly have now to fend for themselves, while

their children are in Colombo or abroad. In addition, displacement from familiar surroundings due to the war, precipitates a confusional state. Further, many who wee too feeble to move quickly, were left behind in their homes by fleeing relatives, when the army moved into the area. In some cases, we were able to arrange for their reunion with their family through the ICRC (Somasundaram, 1994). Some homes for the elderly are being planned and started. The geriatric dimension of medical care will probably become one of our most pressing needs in the future.

General Population

Apart from the specific case histories narrated above, surveys of the general population have also been done which show widespread traumatization and consequent psychosocial problems in the community (Somasundaram & Sivayokan, 1994; Somasundaram, 1996). As can be expected, those affected don't actually seek help for psychosocial problems but many were going to general OPD's, GP's and the traditional healers with somatic complaints (Somasundaram et al, 1993). The problems faced by the internally displaced refugees have also been studied (Reppesgard, 1993; Sivashanmugarajah et al,1994), which show considerable traumatization and the debilitating effect of indirect stresses like poverty, unemployment and lack of food. They manifested with Somatization, Depression (Reppesgard, 1993) and disturbances in functioning of the family system (Jeyanthy et al, 1993).

Conclusion

The devastating effects of war on the minds of men and women are only too clear from the few illustrative case histories recorded here. Apart from the visible external deaths, mutilating injuries and destruction of war, it is the invisible internal psychological trauma to those who survive that is most poignant but least realized. Their symptoms and silent suffering tell an altogether different story about the war. Hopefully the testimony given here will make people realize the tragic cost of war, thereby seek alternate ways to solve their conflicts and problems. Perhaps the most untoward results of the climate of terror and cult of violence that has come to pervade the once peace loving society, is the long-term effects on developing children. By all appearances violence, brutalization and disrespect, for human life and basic rights is fast becoming part and parcel of Tamil society, and a way of life for the next few generations.

REFERENCE FOR CHAPTER 5

1. American Psychiatric Association (1986,1994). Diagnostic and Statistical Manual of Mental Disorders (3rd Ed.,DSM-III), (4 Ed.,DSM IV), APA, Washington.
2. Andreason, N. (1985). Posttraumatic Stress Disorder. in Comprehensive Textbook of Psychiatry, Ed.by Kaplan, H.I. & Sadock, B.J., Williams & Wilkins Co., USA.
3. Arunakirinathan, T., Sasikanthan, A., Sivashankar, R. & Somasundaram, D.J. (1993). A study of Psychological Consequences of Traumatic Stress in School Children Under 12 years. Paper Presented at the Ninth Annual Scientific Sessions, Jaffna Medical Association, 1993.
4. Bandura, A. and Walters, R. (1963). Social learning and Personality development. New York: Holt, Rihehart and Winston.
5. Bleich, A., Garb, R. and Kettler, M. (1986). Treatment of prolonged Combat reaction. British Journal of Psychiatry, 148, pp.493-496.
6. Burvill, P.W. (1980). Changing Patterns of Suicide in Australia 1910-1977. Acta Psychiatrica Scandinavica, 62, pp.258-268.
7. Chandraseharan, S. (1996). Fall in nationwide admissions of Tamil Students to University due to the educational deterioration in Jaffna students.Virakesari (Mar 4, 1996), Colombo.
8. Dept.of Education, Jaffna, 1994.
9. Durkheim, N. (1951). Suicide, Translated by J.A. Spaulding & G. Simpson, Free Press, Illinois.
10. Ganesvaran, T., Subramaiam, S., Mahadevan, K. (1984). Suicide in a Northern Town of Sri Lanka, Acta Psyhiatrica Scandinavica, 69, pp.420-425.
11. Ganesvaran, T., Somasundaram, D.J. and Rajarajeswaran, R. (1982). The Mentally Disordered Referred by Courts. Jaffna Medical Journal, VOL XVII NO. 2, pp.83-85.
12. Ganesvaran,T. & Rajarajeswaran, R. (1989). Attempted Suicide in Jaffna, Jaffna Medical Journal.
13. Ganesvaran, T. & Rajarajeswaran, R. (1983). Consultation in Out Patient Psychiatric Clinic in General Hospital, Jaffna. Paper Presented at the Second Annual Sessions of Jaffna Medical Association, 1983.
14. Geevathasan, M.G., Somasundaram, D.J. & Parameshwaran, S.V. (1993). Psychological Consequence of War on Adolescents. Paper Presented at the Ninth Annual Scientific Sessions, Jaffna Medical Association, 1993.

15. Health Reach (1996). The Health of Children in Conflict zones of Sri Lanka.ed. J. Perera, Centre for International Health and the Centre for Peace Studies, McMaster University, Hamilton, Canada.

16. Hilgard, E.R., Atkinson, R.L. and Atkinson, R.C. (1979). Introduction to Psychology. New York: Harcourt Brace Jovannovic, Inc.

17. Horowitz, M.J. (1986). Stress Response Syndrome.Jason Aronsoo Inc., New York.

18. Ihezue, U.H. (1983). Psychiatric in-patients in Anambra state, Nigeria. Acta Psychiatrica Scandinavica, 68, pp.277-286.

19. Institute for Human Rights (1996). Out-Reach Medical Project. Unpublished data, Colombo.

20. Jaipur Foot Programme (1988). First Anniversary Souvernier. July 1, 1988, Jaffna.

21. Jones, E. (1943). Psychology and War Conditions. Paper on War Conditions, Balliero Tindall & Cox, London.

22. Jong, Joop T.V.M. de (1997). TPO Program for the Identification, Management and Prevention of Psychosocial and Mental Health Problems of Refugees and Victims of Organized Violence within Primary Health Care of Adults and Children.TPO, Amsterdam.

23. Jeyanthy, K., Loshani, N.A. & Sivarajini, G. (1993). A study of Psychological Consequences of Displacamsnt on Family Members. III MBBS Research project, Dept. Of Community Medicine,University of Jaffna, 1993.

24. Kelman, H.C. (1973). Violence without Moral restraint, Reflections on the Dehumanisation of Victims and Victimisers.Journal of Social Issues, 29, 25.

25. Kleinman, A. (1986). Illness Narratives, Havard University Press, USA.

26. Lakshmman, N. & Sivashankar, R. (1994), War Stress in Children. Paper presented at Seminar on Child Mental Health. Shantiam, Jaffna.

27. Lewis, A. (1942). Incidence of Neurosis in England Under War Conditions. Lancet, Aug 15, 1942. 175-183.

28. Lifton, R.J. (1967). Death in Life: Survivors of Hiroshima. Random House, New York.

29. Malhotra, H.K., Inam, A.S. & Wig, N.N. (1977). Public Opinion and the Child Guidance Clinics in India. Indian Journal of Psychiatry, 19,14.

30. Manoharan & Gnanakuar (1988). Psychological Consequences of Losing a Limb. Center for Better Society, Jaffna.

31. Nasr, S., Pasy, J. & Flaherty, J.A. (1983). Psychiatric Effects of the Civil War in Lebanon. Psychiatric Journal of the University of Ottawa, 8:4, 208-212.

32. Red Barna (198_) Bitter Waters-The effects on Children of the Stress of Unrest. Oslo.

33. Rasiah, S. & Nadarajah (1994). A Study of Psychological Consequences of Environmental Stress on Pre-School Children. Paper presented at the Seminar on Child Mental Health. Shantiam, Jaffna.

34. Reppesgard, H.O. (1993). Studies on Psychosocial problems among Displaced people in Sri Lanka, How to Counsel and to set up a Counselling Organization. FORUT, Colombo.

35. Rosenbeck, R. (1985). The Malignant Post-Vietnam Stress Syndrome. American Journal of Orthopsychiatry, 55:2, 319-32.

36. Rosenbech, R. (1986). Impact of Posttraumatic Stress Disorder of World War II on the Next Generation. The Journal of Nervous and Mental Diseases, 174, 319-27.

37. Shepard, M., Brown, A.M., Cooper, B. and Kalton, G.W. (1966). Psychiatric illness in General Practice. London: Oxford University Press.

38. Sivachandran, S. (1994). Health of Women and the Elderly in Victims of War in Sri Lanka. Eds. Arulanantham, S., Raatneswaran, S. & Streeharan, N. Medical Institute of Tamils, London.

39. Sivashanmugarajah, S., Kalaivany, S. & Somasundaram, D.J. (1994). A Study of War trauma in the North of Sri Lanka. Unpublished data from NARESA Research project, Dept. Of Psychiatry, University of Jaffna.

40. Sierles, F.S., Chen, J.J. & Robert, E.M. (1983). Posttraumatic Stress Disorder and Concurrent Psychiatric Illness: A Preliminary Report. American Journal of Psychiatry,140:9.1177-9.

41. Somasundaram, D.J. and Sivayokan, S. (1994). War Trauma in a Civilian Population. British Journal of Psychiatry, 165, 524-527.

42. Somasundaram, D.J. (1997). Treatment of Massive Trauma due to War. Advances in Psychiatric Treatment, In press.

43. Somasundaram, D.J. & Rajadurai, S. (1995). War and Suicide. Acta Psychiatrica Scandinavica, 91,1-4.

44. Somasundaram, D.J. Yoganathan, S. and Ganesvaran, T. (1988). Schizophrenia in Sri Lanka Tamils-A Descriptive Study. Ceylon Medical Journal, 38, 131-135.

45. Somasundaram, D.J., Yoganathan, S., Ganesvaran, T. & Mahadevan, K. (1985). Psychosocial profile of Psychiatric Admissions in Northern Sri Lanka. Jaffna Medical Journal, 20, 79-89.

46. Somasundaram, D.J. (1993). Child Trauma. Dr. A. Sivapathasundaram Third Memorial Lectture, University of Jaffna.

47. Somasundaram, D.J. (1996). Post Traumatic Responses to Aerial Bombing. Social Science & Medicine, 42, 1465-1471.

48. Somasundaram, D.J. & Prabaharan, S. Sivayokan, S. & Somasundaram, S. (1993). War Stress and Psychosocial problems in OPD Attenders at Jaffna. Paper presented at Ninth Annual Scientific Sessions, Jaffna Medical Associtions, Jaffna.

49. Somnier, T.E. & Genefke, I.K. (1986). Psychotherapy for Victims of Torture. British Journal of Psychiatry, 149:323-29.

50. Theivendran, R. (1987). Unpublished Study of Miscarriages among Refugees. personal Communication.

51. Trautman, E.C. (1964). Fear and Panic in Nazi Concentration Camps: A Biosocial Evaluation of the Chronic Anxiety Syndrome. International Journal of Social Psychiatry, 10:134-41.

52. Tressman, B. (1968). Adolescent Children of Concentration Camp Survivors. Canadian Psychiatric Association Journal, 13(2), pp.121-123.

53. University of Jaffna (1994). Memoranda to University Grants Commission. Jaffna.

54. Vincent, F.A. (1990). Heroin Addiction in Jaffna. Study for Department of Community Medicine, University of Jaffna.

55. Walker, J.I. & Coneur, J.C. (1982) Vietnam Veterans-Their Problems Continue. Journal of American Medical Association, 170:174-130.

56. Weisaeth, L. (1984). Stress Reactions to an Industrial Disaster. Unpublished Paper, Oslo.

57. World Health Organization (1978,1992). Mental Disorders: Glossary and Guide to their Classification in Accordance with the Ninth Revision of the International Classification of Diseases, (ICD-9) and Tenth revision (ICD-10),WHO. Geneva.

58. Wilson, J.P. (1988). A Preson-Environment Model of Traumatic Stress Reactions. in Trauma, Transformation and Healing, Brunner/Mazel, New York.

59. Wing, J.K. (1978). Schizophrenia Towards a new Synthesis. London: Acadenic Press.

60. Yager, T., Laufer, R. & Gallops, M. (1984). Some Problems Associated with War Experience in Men of the Vietnam War Generation. Archives of General Psychiatry, 41:327-9.

CHAPTER 6

PSYCHOLOGICAL IMPACT OF AN ACUTE WAR

THE GHOST's SONG

Guns on both sides
me in the middle
an innocent commoner
that is my name.

I have no city
I once did;
now it is gone
(thanks to holy India!).

Guns on both sides
me in the middle;
a burning fire
me in the middle.

He says "sit"
the other says "stand";
he says "go"
the other says "come."

He said "die"
another said "live";
he slew the body
another killed the soul.

And I became
a ghost.

-**Cheran**

(Translated by Chelva Kanaganayakam)

Introduction (1987-1988)

The trauma of the Indian Army Operation in Jaffna during the months of October, November and December in 1987 affected everyone living in the area. In those few months the death, injuries and destruction reached a scale and severity not experienced before. But more than the physical catastrophe it was the psychological trauma that went deeper, leaving a permanent scar in the mind of the survivors. More than anything else it was the sudden change in the role of the Indian army from the friendly savior to belligerent destroyer that most found difficult to accept or adapt to. Again, the people were caught between two violent forces who wrestled for the loyalty, obedience and control over the people's minds. That India lost this essential battle for the mind despite (or due to) the cost in terms of civilian, army and militant casualties, the widespread devastation of homes, building and property and hardships of army occupation was evidenced by their eventual humble withdrawal. The story of this traumatic period can be found recorded in the scars

that were left behind. The psychological reactions and mental disorders caused by the acute war are a revealing testimony to the silent suffering of the people.

Traumatic Environment

During the months of October and November 1987, Jaffna witnessed death and destruction on a scale unprecedented in its history. Military Operations had been going on full scale in Eastern Sri Lanka and to a limited extent in the North as part of the chronic civil war being waged in the last few years. The so-called *'Operation Liberation'* in the middle of 1987 in the Vadammarachchi area brought the action into the heartland of the Tamils of Sri Lanka and a similar fate for the rest of the Jaffna peninsula had been in the offing and frequently threatened. It is ironic, that it was left to the Indians who had all along been championing the Tamil cause and had been looked upon as their saviors and protectors to complete this task.

It was this complete change in the role of India, from the positive, beneficent image to the negative one that created much difficulty and trauma for the Tamil people. The Tigers had struggled to portray themselves as the sole authority among the Tamils. When India challenged this view and there were moves to sharing of power with other Tamil groups, the Tigers had to fight for their construction of reality. India on the other hand wanted the recognition of her paramount position in the South Asian region in general, and a supervisory control over events in the North and East of Sri Lanka in particular. The clash in the various constructions of reality and the need to win over the Tamil mind to accepting one of these views, in short the authority of India or the Tigers to rule them, necessitated a violent operation. In this battle for the mind, the Tigers succeeded in provoking India to react violently against the civilians and managed to create a new reality turning the former friends into the enemy. The Sri Lanka government of 'JR' Jeyawardena and his minister for National Security playing no small role in cleverly engineering the confrontation.

A comparable number of deaths may have been claimed by epidemics in the past. But the agony, destruction, terror and mayhem of 'complete' modern warfare and the duration of continued fighting far surpassed anything Jaffna has ever experienced.

Though not by any means a new or unique experience in the annals of the history of war, an attempt is made to record the psychological impact of this acute war from the perspective of a participant observer. It is based on an earlier, more detailed, clinical study, the psychological sequelae to the chronic civil war in Northern Sri Lanka during the period 1983-1987, presented in the last chapter.

The Indian intervention in Jaffna can be divided into four distinct phases. The first covered the period after the Indo-Lanka Peace accord signed on July 29, 1987 in a bid to end the continuing ethnic war. Indian troops, calling themselves the Indian Peace Keeping Force (IPKF) were airlifted into Jaffna that night itself, while a larger contingent followed by sea. This period of entry extended up to the end of September and was characterized by an initial euphoria followed by suspicion, uneasiness and mounting opposition, but with impeccable behavior on the part of the Indian Army (IPKF). The second period was of complete war, when the Indians launched the so-called '*Operation Pawan*' to capture Jaffna from Tiger (the Tamil militant group) control (Hoole et al, 1988). It covered the period from October to December 1987 and forms the essential background to this study. The report essentially follows the same framework as the earlier study of the civil war but is more from the view point of a participant-observer with a subjective colouring, as the author was caught in the direct fighting and became a refugee for over a month, thus providing the opportunity to experience and observe much of the traumatic events first hand. But primarily, it is a study of the patients who had been traumatized by the war and came for treatment to the University Psychiatric Unit at Tellipallai.

It is to the credit of the Indians that the third period from January 1988, after their violent '*pacification*' of the Jaffna peninsula, saw a gradual cessation of hostilities and imposition of 'normalcy' with relative peace, ensuring *'security to life, limb and property'* to the population at large. Yet it has been a period of army occupation and martial law where arrests, detention and torture continued interspersed with sporadic ambushes, guerrilla attacks and political killings by the militants. The outstanding political issues remained unresolved.

The fourth phase saw the war of attrition by the guerrillas taking its toll on the Indian army as it responded with civilian reprisals and attempted to install its own local militia in power. The bitter struggle between the rival Tamil militant groups to win the support of the local population surfaced again during this time. The final withdrawal of India forced these groups also to retreat leaving the Tigers in control. With the beginning of the war between the Tigers and the Sri Lankan army in 1990, the whole process had come a full circle, back to square one. But a lot of blood had flown under the bridge.

Reports

The reader will readily appreciate that the study covers mainly the period of acute war (October-December 1987) and thus the belligerent behavior of the Indian Jawan here portrayed may only reflect the conditions of a complete war situation, as in similar circumstances the world over.

Transient Stress Reactions

A significant phenomena during these days was the large number of refugees. More than 75% of the civilians from affected areas were displaced at one time or another, the figure reaching almost 100% in some areas.

Refugee status creates a feeling of being uprooted and loss of traditional support, with the collapse of the world they knew and the regular routine that was the framework of their daily life. Many civilians sought refuge at temples and schools as advised by the Indian army. These same temples and schools were later shelled resulting in a large number of civilian deaths. It was a tragedy that even the refugee camps such as the Kokuvil Hindu College, Chundukuli Girls College, Jaffna Railway Station, Inuvil Pillayar Kovil, and Kooramban Catholic Church turned out to be death traps. No place was safe. In some refugee centres people were paraded in front of masked 'nodders', youth were shot and others taken away. At Manipay Hindu Ladies College women were molested. Decomposing bodies were not allowed to be burnt or buried. Large numbers were confined into small spaces for long periods of time, sometimes 2 to 3 days. They were without food and water, with perhaps '*kanchy*' in some places. They had to relieve themselves within the rooms they were in. Children and the old were badly affected. Appeals to the Indian Army fell on deaf ears or were answered with threats of being shot.

As the army advanced behind them, the refugees trekked over long distances seeking safe refugee shelters. The old and disabled had to be left behind. A large number fled from one part of the peninsula to another, until eventually, there was no place left. The more enterprising fled to Killinochchi, Vavuniya, Colombo, Singapore, UK, Canada, Australia.....

The accumulated stress of leaving their homes and usual habitat was accentuated by a complete disruption of normal life patterns, together with lack of food, rest, medical attention and a continuing atmosphere of fear and terror. Another important psychological stressor the civilian population faced was the sudden change of role of the Indians. It has been found that an individual is better able to cope if he understands and accepts the necessity for any particular stress. The Tamils coped with the chronic civil war with the Sri Lankan Army and the accompanying atrocities because they believed they were involved in a legitimate struggle for their rights. For the Tamils of Sri Lanka, the tragedy of the Indian action lay in the fact that India, the source of their culture and traditions, a holy place of pilgrimage, had always been held in the most revered terms. When the Indian army suddenly started treating the local population as its enemy, killing and destroying remorselessly, this metamorphosis from friend and protector to aggressor and enemy was undoubtedly the most shocking factor of the whole war. There developed in their minds

what has been called cognitive dissonance, two conflicting and irreconcilable images of 'mother' India.

The public was unprepared for the sudden onslaught. People had breathed a sigh of relief at the coming of the Indians and even stopped keeping stocks of essential items as was customary at the time of the Sri Lankan Army activities. The older generation particularly found this change of role difficult to accept and different psychological defense mechanisms like denial, rationalization and intellectualization were resorted to, to cope with this new situation. Some even denied that it was the Indian Army that was shelling and shooting, it was probably the Sri Lankan Army[1], and some claimed that only the militants were being killed and the civilian had nothing to worry about. Others claimed the atrocities were perpetuated by the North Indians, while the South Indians were 'good' and trying to stop them.

Others rationalized saying that this was all necessary, *"we will understand only later"*.... *"the action will be over in a few days and then there will be permanent peace"*. They continued to believe completely the psychological propaganda spewed out by the Indian radio special programs (*Anpuvali* and *Veti Malai*). They continued to have faith and trust in the Indian army, till they were confronted with the stark reality of seeing their houses shelled or their friendly approaches answered by a hail of bullets. And still some continued to justify the consequences as something that happens with any army: '*We would have fared much worse under the Sri Lankan Army*'. And then there were those who looked at it intellectually. For example, a doctor compared it to a surgical procedure to excise a cancerous growth, where a certain amount of healthy tissue has to be removed (only here, excessive healthy tissues was removed due to careless surgery endangering the life of the patient while the cancerous cells escaped, leading to widespread metastasis). By these and similar explanations people sought to maintain their mental balance, their psychological equilibrium in the face of the unexpected Indian attack.

It has been found that information facilitates adaptive reaction to stress. Lack of information and breakdown in communication leads to much confusion, apprehension and disorganization. The local population had no precise information about what was going on, rumors and half-truths circulated from mouth to mouth. The local Indian radio programs (*Anbu vali, Veti Malai*) and the Tiger paper *Elamurasu*, gave completely opposing versions. Each side announced victory after victory with heavy casualties in the enemy. What became increasingly clear was that these casualties referred to civilians and that heavy fighting

[1] Soon people were saying that the Sri Lankan Army was much better, at least they showed respect to the elderly, professionals, educated etc. This opinion was to change again when the Indians left and the Sri Lankan Army took over the operations. Some recalled the Indian Army with nostalgia.

continued. In mid November the ***Elamurasu*** was silenced and the Indian radio happily continued to announce the return of normalcy, opening of shops, offices, schools, restoration of services etc. when in actual fact people were still afraid to walk around in their own compounds as full scale military operations were still in progress. Only two months later did civilian life limp back to 'normalcy' once the hostility had decreased-by January 1988. These competing constructions of reality by the respective propaganda machines were at complete odds with public reality.

Even those few army personnel who could communicate in English or Tamil were terse, snappy or threatening. The Indian army was evidently not interested. Everyone was the enemy. There was nothing to talk about. The civilians, usually leading senior citizens, who tried to approach the Indians holding white flags were rebuffed rudely or sent hurrying by a hail of bullets above their heads. The Tellipallai District Hospital was shelled heavily for 2.5 hours, injuring members of the staff and damaging many buildings, although at that time, there was no resistance or the presence of militants in or anywhere near the hospital. After the shelling, a delegation of senior staff in white uniform together with ambulant patients approached the nearby camp but were stopped about 100 yards away. The sentry was seen to use the telephone and then shouted at the delegates to get back or be shot. Again on the 17 October, 1987, troops fired on the hospital and on uniformed staff, while moving on the road in front. Although the army frequently moved along Hospital Road, no effort was made to establish contact with the large institution nearby. The first communication didn't occur until November 11-an entire month later.

This lack of communication led to much uncertainty and helplessness in the minds of the public. They didn't know what was expected of them, what rules and regulations to follow. Most stress reactions show spontaneous recovery once the stress is withdrawn as did happen when people started returning to their homes, communication and contact was established, clearer information available and the atmosphere of hostility and terror was defused (beginning from January 1988). But the fact that the stress had been fairly severe, was shown by the long time people took to recover. The refractory period was prolonged, unlike after the Sri Lankan operations, where people resumed civil life immediately or had learned to continue despite military activity. A haunting sense of shock, disbelief and disillusionment, fear and terror, loss and sorrow, still lingers like a bad taste. The Tamil man will not easily forget this experience.

On the positive side, some adapted well to the stress and showed hidden strengths and leadership qualities. Particularly encouraging was that those individuals considered as trouble makers or administrative headaches during normal times, acted with heroism and initiative.

At the Jaffna University, the staff of the Mathematics and Anatomy Departments took the initiative to establish initial contact with the then still belligerent army, took over the University and started the reorganization process, thereby preventing further damage and looting. At the Tellipallai District Hospital, a lady doctor, though with child, continued to run the hospital despite heavy shelling and direct firing on the hospital and her quarters. When most of the staff had fled, she stayed on with four nurses and looked after the patients for over two months, doing yeoman service at this critical juncture. The local population as a whole, after some initial panic and disorganization, learned to cope with the situation for two months, while fierce battles raged on all fronts, amidst exploding shells and gunfire, a continuous shoot-at-sight curfew and a breakdown of all civil organization. The usual amenities of civilized life that they had been so used to were suddenly not there. What is considered as essential services like electricity, water supply, mails, transport and access to main roads, hospitals and medical services, banks and circulation of money, jobs and salaries ceased to exist for over two months. People were caught unawares without any stocks. Shops were closed. A large number of refugees were on the move. The injured needed medical care. The sick and disabled, infants and pregnant mothers, unfed domestic animals-the problems were unlimited. And yet the reaction was often inspiring and heart warming. People became accommodating, forgot old quarrels or helped complete strangers. Caste and class barriers were broken. Refugees were given shelter and food shared. People came forward to donate bags of rice, flour, milk and vegetables to refugee camps. Food for the infants, care for the sick and solace for the grieved were forthcoming. Refugees were fed and clothed for long periods, establishing new friendships. Small acts of heroism such as retrieving the injured and taking them to hospital facing great personal danger, were much in evidence. At St. Anthony's Church at Chunnakam, eleven severely injured were kept alive overnight by a nurse and St. John's Ambulance Brigade volunteers until midday when permission was given by the army to the Reverend Father to take them to a hospital. At Changuveli, when some young girls were taken away by Jawans, a brave, middle aged woman approached the army camp, a very risky undertaking in those shoot-on-sight days and raised such a hue and cry that the commanding officer fired some shots into the air and the Jawans returned meekly to camp. The girls escaped being raped.

Communities organized themselves into groups to deal with urgent issues. Enterprising shopkeepers kept the interior areas supplied with essential items at reasonable prices, often taking risks to procure items from neighbouring areas. As a whole, the community managed to withstand the severe pressure for over two months, completely on their own, with no outside help. They had established their resiliency in adversity, self-reliance, self-sufficiency and their ability to live off the land without the modern amenities of civilization. They had lived up to the local '*Palmyra'* tradition.

Yet at general medical clinics held at refugee camps, we found a high incidence of infectious diseases like scabies, gastro-intestinal disturbances like vomiting, diarrhea and dyspepsia and upper respiratory tract infections. Headache, chest pain, dyspnoea, backache, insomnia, abdominal pain, and paraesthesias were common complaints. Most of these symptoms were psychosomatic in origin, expressing the underlying stress. They made a spontaneous recovery on returning to their homes and the cessation of fear and tension. A list of stress factors are given in Table 1.

Table 1 Stress Factors-Operation of the Indian Peace Keeping Force (IPKF) Jaffna and Other areas (October, 1987-1988)

Description	Year	Month	Numbers	SOURCE*
Deaths				
Civilians				
Tamils-Jaffna	1987	Oct to Dec	1320	T.R.R.O.
-do- (Total)	1987-88	Oct, 87 to July, 88	1990	H.H.R.
-do- Other areas	1988	Jan to July	437	H.H.R.
-do-	1987	Oct to Dec	215	H.H.R.
Sinhalese	1988	Jan to Dec	281	Ratwatte, Deputy Minister In Parliament (9.2.96)
Combatants				
Sri Lankan Forces	1987	Oct to Dec	39	H.H.R.
-do-	1988	Jan to July	38	H.H.R.
I.P.K.F. Forces	1987	Oct to Dec	350	Sunday Times (10.7.88)
-do- (Total)	1987-88	Oct, 87 to July, 88	551	K.C. PANT, Indian Defense Minister (28.7.88) Sunday Times (10.7.88)
Militants (LTTE)	1987-88	Oct, 87 to July, 88	500	
Injuries				
I.P.K.F.	1987-88	Oct to July	1526	K.C.PANT, in Rajya Sabha (25.7.88) -Tamil Times (8.'88)
Missing & Disappearance				
Jaffna area	1987	Oct to Dec	01	H.H.R.
-do-	1988	Jan to July	11	H.H.R.
Other areas	1988	Jan to July	49	H.H.R.
	1987	Not Available		
Torture	1988	Jan to July	26	H.H.R.
	1987	Oct to Dec	555	H.H.R.
Injuries-civilian	1988	Jan to July	458	H.H.R.
	1987	Oct to Dec	1667	H.H.R.
Arrests				
Jaffna	1988	Jan to July	1625	H.H.R.
Other areas	1988	-do- Oct to Dec	4343	H.H.R.
Released	1987	Jan to July	32	H.H.R.
	1988	----------	1942	H.H.R.
Damage to Houses (Jaffna area)	1987		3149	T.R.R.O

* Sources quoted include the Tamil Refugees Rehabilitation Organization (T.R.R.O.) and Home for Human Rights (HHR). Information was mainly obtained through Citizen Committees of the area, usually in the form of affidavits from those affected and thus may be a gross underestimates.

-Compiled by L. Dwight, Social Worker

Anxiety

Anxiety disorders were very common. People were found to be tense and fearful, apprehensive of when the fighting would spread to their area. When fighting did break out, they were found to huddle together, or cling to each other. People were extremely vigilant and startled easily. The sound of gun fire or exploding shells caused panic attacks. Some sought shelter behind walls or thick cement roofs-so-called *flats*) Others took flight. These precautionary actions were lifesaving in many instances. The Indian army also seemed to warn the local population of impending attacks in an area with preliminary shooting and shelling. Sleep was frequently disturbed by sounds of fighting or nightmares. On some nights people kept vigil expecting the worst. Some resorted to repeating mantras or short prayers which have been shown to be very effective relaxation techniques that alleviate anxiety.

What has been described as ***existential anxiety*** was also observable in some cases. Death became a pressing reality and people had to deal with that fear daily. What had been quietly forgotten or submerged in the pressures and care of daily life, broke into one's awareness. Man was made aware of his existential state the transience of life-that everything born must die one day. As death stalked the land, the veil that separated life from death was rent asunder and one stood face to face with stark reality. An existential fear gripped everyone. And old mystic compared the present war to the great forces of nature that destroyed-famine, epidemics, cyclones. Grasping for mythical symbols to express his deep feeling, he said "*Mother Kali with her Asura forces from India have descended on Jaffna. I could see her dancing on the streets of Jaffna in those October days".*

Terror

Terror a form of extreme fear, was widely prevalent in the months of October and November. This was not surprising since it was quite evident that there was a deliberate attempt at the time to terrorize the civilian population. The unusual uniformity in the behavior of the Jawan towards the civilians lends support to this assertion. As mentioned earlier, there was no attempt to establish communication or contact with the civilians. Rather, it was actively discouraged. Where there was any conversation from the army, usually during search operations, it was terse, snappy and revealingly stereotyped. *"Any sound from this direction and we will flatten your house and shoot you all!!*".

This was repeated in different situations, in different places, by different Jawans and officers. Was this a standard order? This wall of silence, except for the few belligerent words, caused uncertainty, a feeling of isolation and loneliness, made worse by being cut off from the outside world.

Secondly the Jawans were undoubtedly free to do as they wished. By their words and deeds, the Jawans conveyed the message that they had been given a free hand by the higher-ups. They were not accountable and people felt deserted, alone, without protection, without recourse to justice. An Indian Red Cross doctor remarked that this could only have happened here. "*There was nobody to ask. This never happened in Punjab or in Bangladesh. The army felt free to destroy, kill, loot, rape*". They were allowed to run amok, unchecked for nearly two months. This lack of restraint, the liberty to do as they wished, contributed to the atmosphere of terror. The atmosphere changed gradually from December, as the commanders started to apply some restraint, making the Jawans accountable for their actions and took action on civilian complaints. This did ease the situation somewhat and the Jawans showed much more restraint in their behavior.

A third factor contributing to the reign of terror was the inhuman behaviour of the army. The local population was pushed, shoved and beaten with brutal and callous disregard. Status, age, sex nothing mattered. Lawyers, doctors, engineers, the old, the young, the sick and disabled were humiliated, assaulted or shot even after being identified; whole families were pulled out of their houses and shot. The bloody assault on the Jaffna hospital with the massacre of doctors, nurses and patients, described in detail elsewhere (Hoole et al,1988), was the epitome of this type of barbaric behaviour that struck terror in the hearts of the people.

Fourthly, the indiscriminate shelling, particularly the unpredictability and the terrific noise, were instruments of psychological terror. It is questionable whether the intense shelling of whole areas achieved any military objective. There were at the most only a few thousand militants among 800,000 civilians in Jaffna, whereas the Indians went about it as if it was a conventional war against a large army. One wonders how many of the militants were actually hit by any one of the thousands of shells that fell on Jaffna. As for its psychological effect on the militants, they could be observed to be nonchalantly moving around in casual conversation, quite unperturbed by the exploding shells.

But the persistent shelling of densely populated areas even after large scale resistance and militant mortar shelling ceased, speaks of a more sinister purpose. As mentioned, 67 shells fell on the Tellippalai hospital on October, 12th, with no militants around. The Christa Seva Ashram with well over a thousand refugees was heavily shelled on October, 13th with the chapel collapsing on the incumbent, with no militants around. In addition, there was the so-called 'noise shell' which exploded with a thunder-clap effect. This was obviously a psychological weapon used with deadly effect on the civilians. Nights were spent in abject terror, partly due to what has been called anticipatory anxiety of not knowing when and

where a shell will fall. Some died of psychological shock. A mother who had delivered her second child died suddenly when Chankanai was shelled. Many children never got over the effect of the noise and remain hypersensitive to any loud noise. Two children who had gone to Colombo as refugees, developed severe anxiety and clung to their parents when fire-crackers were set off for the New Year. The animal population too suffered terribly from the noise pollution. Trembling dogs were seen scampering all over, rabbits dropped dead and wild birds vanished from the Jaffna Peninsula. The cry of despair that escaped from an old man in late November reflected the anguish of all living things. "*When will this infernal noise stop? When will the shooting cease? Oh, when will peace return to this land*?" Another devastating aspect of the shells was the destruction of property and mutilation of civilians. Residents at Innuvil hospital heard a shell whiz past overhead and in a few moments Professor Chandrasekaran was carried over the hospital boundary wall with both legs gone and bleeding profusely. That image was to recur in their minds and send them into panic whenever they heard shells. One has to concede to the credit of the Indians, that neither heavy artillery nor the more lethal, fragmenting shells favored by the Sri Lankan Army, was used and heavy bombing not resorted to. But there was no need at all for artillery fire on a civilian population, except as a morale booster for the advancing troops.

A noticeable feature of the heavy destruction due to shelling was that it fell short of Jaffna town itself. There is severe destruction on all roads leading to Jaffna, but stopping just short of the city limits. There was stiff resistance to the army in Jaffna and many civilian deaths but not much destruction of buildings. One wonders why? Could it be that the Indians wanted to preserve Jaffna? But subsequent events such as their hurry to establish '*normalcy*' within the Jaffna town, suggest that they wanted the town intact and whole for their conducted tours for foreign journalists. If this is true, then it shows a degree of pre-planning and a deliberate differential use of the artillery for non-military purposes.

The decision to use terror may have been to wrest control over the civilian population[2] and force them to relinquish their sympathy and support for the LTTE. Perhaps due to their failure to win a quick victory and their gross under-estimation of the LTTE, the Indian army found itself fighting a desperate battle to save face and take Jaffna at all costs. A

[2] The meaning behind the military term 'pacification' became clear only after the war when the army officers made subtle differnetiations between areas. For example, Thenmaradhchi which had seen limited army action was still tense and considered troublesome. Residents were required to carry Indian issued ID cards etc. Checks, sudden curfews and search operations following mililtant action was common in that area. It had not been 'pacified', subjugated, brought under control. The local spirit had not been broken. This entails a certain amount of terror, a show of force-a few shot, a few arrested, a few beaten up and aggressive behaviour until the spirit of resistance is broken, and the people submit to the new power.

second possible reason may have been a reaction to the fighting tactics of the LTTE-guerrilla warfare in an urban setting from heavily built up areas. The Civilian population was used for cover. Guerrillas fought from hospitals, temples and schools, women and children performed military tasks and allegedly, dead bodies of Jawans were desecrated. At times these tactics appeared to be deliberately calculated to provoke the Indian army into reprisal attacks on civilians. These may not have been the norms of war, the *dharma*, the Indian army expected. If one is to rationalize the behaviour of the Jawans at all it must be in the context of their being psychologically unprepared for this type of battle, and as a rage reaction to the way it was fought.

It has been reported that Jawans were airlifted over long distances and immediately pressed into battle without adequate rest. Others came with only a change of clothes expecting the action to be a pushover, completed in a few days. They were handicapped by fighting an elusive enemy who used guerrilla tactics, while they struck to rigid conventional lines, resulting in heavy casualties. Few had any knowledge of the political situation. Put in a completely foreign environment, ignorant of the local language and customs, they may have undergone a paranoid reaction. They were suspicious of everyone, treating the whole population as the enemy, as active supporters of the LTTE.

"*You LTTE?...Where LTTE?... LTTE, LTTE...*" was the phrase constantly on their lips. It became an obsession for them. They were pressed into battle mentally unprepared. Expecting a quick finish, but meeting fierce resistance, in a foreign environment, they reacted with an uncontrolled frenzy and vented their murderous fury on innocent civilians. Later on, a soldier tried to explain their behaviour by saying "*when one of us dies, our blood begins to boil and we know not what we are doing.*"

In the final analysis the ultimate responsibility for what ensued, rests with the higher command, and even more with the political administrators in Delhi and their representative in Colombo, for putting their men in a difficult situation.

The use of terror may have worked to some extent on a society that has learned the language of violence and was used to being ruled by terror. But to continue to rule by the use of terror is costly and impracticable, and the Indians may have realized this as evidenced by their efforts to win the hearts and minds of the Tamil man by more human methods. Their (February, 1988) search operation in Batticaloa were carried out with much more restraint and consideration for the civilians.

The terror of those days still persists as a tormenting memory, a recurrent nightmare. The Jaffna man is unlikely to forget that ordeal in a hurry as can be seen by his lukewarm

responses to friendly overtures of the army personnel. After all, friendship is not something that can be turned on and off like a switch.

Grief Reactions

Grief Reactions were common during this period due to the suddenness and the psychologically traumatizing circumstances surrounding the unexpected death of loved ones (the noise, the blood, mutilating injuries, pain, lack of medical attention, standing helpless as loved ones suffered and died).

A middle aged engineer whose three children and mother-in-law had been pulled out of their home and shot dead on the street for no apparent reason developed a severe grief reaction with secondary alcoholism. He spent his days in deep sorrow with attacks of crying spells, the pangs of grief buffeting him like waves. His mind was preoccupied with thoughts of his children. He complained of loss of purpose in life with suicidal ruminations. His nights were particularly bad with recurrent nightmares about his children and their suffering, especially his pretty daughter. The soldier had lifted up her frock and shot her through the groin. She could not walk and had to drag herself along the road and finally bled to death for lack of adequate medical attention. This image kept haunting his mind. "She was deeply loved, and I raised her without a worry. And now she has to suffer like this... It's unbearable..." he would say, breaking into sobs. Hostility, a feature typical of grief reaction, was apparent in his want of revenge, "I will personally kill these soldiers", and his action to file a case. His wife too was inconsolable and he expressed a fear that she would cry herself to death. They felt that without their children, life had lost its meaning. Previously an occasional drinker, he had now started drinking heavily and was in a state of intoxication most of the day and night.

A 24 year old farmer from Alaveddy developed a typical grief reaction when his father and uncle were shot while attending to their cows. He became restless with irrational and incoherent speech, and behaved in an abnormal and bizarre way. The picture was that of a psychotic reaction and required Electro Convulsive Therapy (ECT).

In some cases, multiple deaths of close relations precipitated decompensation.

A nurse, previously of a jovial personality developed a severe depressive illness when several of her close relations died. She needed intensive treatment before she gradually recovered.

A young mother lost her child and then her husband in quick succession to shelling. She developed a 'Schizophreniform' Reactive Psychosis that fortunately responded to treatment.

Hysteria

Hysterical Neurosis is a term used to denote the adaptation of a '*sick role*' by a person under psychological stress. This may take the form of Conversion symptoms where the patient 'converts' unbearable stress into physical complaints like paralysis or mutism, or the patient may 'dissociate', banishing the stress condition into their unconsciousness in the form of Amnesia (loss of memory or 'psychological forgetting') or Fugue (psychological flight). This mechanism helps the patient to avoid or escape from facing the stress directly and provides for gradually adjusting or coping with the situation.

Miss. K., age 18 years was an intelligent and talented student living with her family at Kopay. Two days after the Indian offensive started, her father to whom she was very closely attached, had taken the family to the refugee camp and returned to his farm. The patient had not heard from her father since then and had been told that he had been killed. On returning to their farm one month later they had found only a human skull. The mother noticed that the girl was very moody and depressed from that time, given to crying spells. She reported that she always hoped that her father would return and looked for him everywhere. When seeing a lone man on the street, she would run up to him to ascertain if it was her father. At times she had a vision of her father. One day there had been a funeral in the neighbourhood of a person who had been shot by the army. She had become excited at that time, ran around wildly, crying and shouting. Later, she could not remember anything that had happened. At another time, she had lost her voice and recovered after being treated by a general practitioner. She had wanted to continue her studies but was unable to do so as the family had become destitute after the father's death. She then tried her hand at writing an autobiographical novel but couldn't go on due to the emotion that was evoked. One day she was found wandering around aimlessly in another village and was brought to the psychiatric unit. She was found to be in a distraught state, unable to speak. Her identity or address could not be established. After speaking to her quietly, reassuring her and giving support, she started sobbing and shouted, "Father has gone to the Gods". She was sedated, and made a gradual return to normal consciousness in the ward environment, but had no memory for what had happened. It transpired that on the day before her admission, the Indian army had come checking her house. This had activated her memory of her father being

shot by the army. She had dissociated, going into a fugue, wandering far from home, not knowing who she was or where she had come from. On admission, she had a Hysterical Aphonia and after recovery, a Hysterical Amnesia for the period of the fugue. She recovered rapidly regaining 'islands' of her lost memory. Her mother was then contacted and the whole story was pieced together. It was found that the patient was prone to Hysterical Attacks when reminded of her father, for example, a TV program depicting army action resulted in her fainting suddenly. Considerable emotion was generated on talking about the father and this may have had a therapeutic or 'cathartic' effect. Steps were taken to provide the family with financial support, with bereavement counselling for the patient for her unresolved Grief Reaction.

Reactive Depression

Many patients with depression due to various types of losses such as death of loved ones, destruction of home, displacement, loss of belongings, rape or torture presented themselves to the psychiatric unit as well as to OPD's, refugee camp clinics, and general practice with 'vital', physical complaints. For some, there was a period of latency between the stressful event and the onset of symptoms. The majority made a spontaneous recovery without specific therapy.

An Indian Army doctor speaking to the author after his arrival following the July 1987 peace accord, expressed his shock and sorrow at seeing so many houses destroyed. His camp was near Kurumbasiddy, where most houses had been destroyed by the Sri Lankan Army. I agreed saying that it was built with their life earnings. He replied, "*To see all that destroyed must be heart rendering*". I don't know whether he was here to see what happened in October and November and whether he would be still sympathetic.

In some cases, the straw that broke the camel's back, the loss that proved to be just too much to bear after seeing their houses damaged or destroyed, that which tipped the scale into full blown Depressive illness, was the loss of their personnel belongings due to looting by the locals. A very unfortunate outcome of the prevailing situation, a state of anarchy without law or order, was the widespread looting that followed the IPKF operation. Those vulnerable, those most affected were the ones who had already suffered much. The looting was perhaps a reaction to the intense violence that had been unleashed on the community.

The looting, rape and heavy drinking seen in the army after heavy fighting and the

looting by the locals could be a form of emotional release observed in the recoil phase after a major catastrophe such as war, where a small proportion of victims exhibit '***psychopathic liberation'***(Kinston & Rosser,1974).

Post-Traumatic Stress Disorder (PTSD)

PTSD is a characteristic syndrome that follows the experiencing of an exceptionally threatening stress, particularly danger to life. Essential features include repeated reliving of the trauma in imagery, intrusive memories, flash backs or in dreams as nightmares. In addition, a sense of numbness or emotional blunting; avoidance of any stimuli that resemble or symbolize the original trauma which when encountered cause an exacerbation of symptoms, and a state of hyperarousal and hypervigilance are also found. It is noteworthy that the main complaint of patients with the Post-traumatic Stress Syndrome seeking treatment at the Psychiatric Unit was always of other disorders, particularly of a physical nature. The tendency to Somatization of psychological problems into bodily symptoms is common in our culture and may be due to the receptivity shown by doctors to somatic complaints. Anxiety and /or Depression or other recognizable psychiatric disorders were also present in these patients.

Miss. S, 28 years, was at home, when the army had entered her neighbour's house where her life long friend lived. Due to fear, they did not venture out that day. Early next morning she had gone to investigate what had happened and found her friend's body floating in the well in a "begging, praying" posture. Later, post-mortem and reconstruction of events revealed that she had been raped, after which she had apparently jumped into the well. After sometime the patient became withdrawn and stopped doing her regular work. She was given to crying spells. The parents noticed that she completely avoided going to the neighbour's house which she had used to visit almost daily. Occasionally she was seen to hide behind trees in their compound, to look at the fateful well from far off. Whenever the army was in the vicinity, she used to get into a panic and run inside the house. She was eventually brought to the Psychiatric Unit two years later with a complaint of severe headache not responding to medication and social withdrawal. On mental state examination it was found that she was frequently disturbed by repeated images of her friend's body in the praying posture lying in the well. Her headache was related to the occurrence of these images. Her mood was depressed with loss of interest in her work and life. She gradually responded to anti-depressant medication and psychotherapy.

A young militant was admitted in an altered state of consciousness with a history of repeated 'fits'. In hospital the 'fits' were found to follow a functional pattern. Piecing together the background events, it was revealed that he had been captured, detained and tortured by a rival group. On not eliciting any important information from him, his sister had been arrested, tortured and finally killed in front of him. He had subsequently managed to escape and rejoin his group. But during periods of inactivity memories of his sister being tortured and killed kept intruding into his mind. At this time, he used to fall on the ground and have a 'fit'. Gradually he began to communicate, admitted that these memories were disturbing him and that he lost control at this time. Later he felt a burning sense of rage at the rival group, wanting to take revenge and destroy them. The opportunity to talk about his traumatic experience and ventilate his feelings were cathartic and therapeutic.

Mr. R., 24 years old, is a Jaffna University student who had been caught up in the initial fighting at the University in October, 1987 and had to flee for his life from cover to cover, amidst intense cross fire and helicopter strafing. Since that time memories of his flight and the sound of gunfire used to recur in his mind. Incidents similar to the original event such as the sound of helicopters used to set off panic attacks. He became hyper-alert and hyper-vigilant, startling easily to unexpected noises. He complained of loss of memory and concentration, sleepiness, diarrhoea, vomiting and attacks of giddiness. He began to get attacks of fits resembling Psychomotor epilepsy for which he was admitted and treated at various hospitals including the one in Batticaloa and Neurology clinics in Jaffna and Colombo where an EEG was done. As all the investigations proved inconclusive and he responded poorly and his symptoms worsened, he was finally referred to the psychiatric clinic. On mental state examination he was found to be depressed, anxious with psychosomatic symptoms referable to his initial traumatic experience. He was started on psychotherapy and is now able to continue his studies, with a gradual improvement in his condition.

Miss. R, was an 8 year old child doing well in her studies. During the war, there had been shelling & fighting near their home. The child had seen the body of her friend next door which had been hit by a shell, exposing the intestines. They had to flee as refugees passing terrifying scenes of destruction, mutilated bodies, etc., before eventually escaping to Colombo. The family was only able to return home after more than a year. The child began to behave stubbornly, withdraw from the family and be fearful in the nights. She had lost her appetite. On questioning it was found that she gets up in the night screaming, drenched in sweat but unable to recall her dreams. She had also started bed wetting whereas she had been dry before these experiences. In view of the enuresis and night terrors she was put up on Imipramine and Diazepam for the night. Play and art therapy may be the more appropriate ways of treatment. Unfortunately appropriately trained personnel and facilities to care for traumatized children are completely lacking in the North and East.

Mr. N. S., 21 year old farmer from Vavuniya was detained by the Sri Lankan forces for less than one month. During this time, he was confined in a pit with other detainees. They were taken out for ablutions and other needs, and were assaulted intermittently. Once he had been made to lie on the ground and they had stepped on him and kicked him with their boots till he lost consciousness. He had taken these events quite philosophically as his brother who was actually in the movement had been taken in with him but soon released. He was happy that his brother was free. Although the guards used to be drunk, crack jokes and laugh as they tortured him, he had replied in kind. On being released, according to his history, there were no ill effects from this experience. When the Indian army had mounted an offensive in their area, there had been intense shelling and firing, death and destruction all around him with many civilian casualties including his neighbours and close relations. In one incident, they had been loading the injured into a cart to take them for medical treatment, when the Indian army had unexpectedly arrived on the scene and started firing at them. They were able to make good their escape leaving behind the injured. Following these events, he began to develop multiple somatic complaints such as headache, backache, numbness, dyspnoea etc. He had seen several doctors, undergone many investigations and taken a variety of treatment. According to him there was no doctor he had not seen in Vavuniya and Jaffna, no tests (investigation) that had not been done, no medicine or injection that had not been administered to him. He had decided that if this 'mental treatment' also failed he would commit suicide. He said that for this he had the necessary insecticide back in the farm. He had misgivings about coming to the psychiatric clinic, even resisted the referral, but the doctor had

insisted that he go. On further questioning, he had loss of appetite, insomnia and felt very lonely. He admitted to re-experiencing the events associated with the shelling and firing as intrusive memories and nightmares. His somatic symptoms (Somatization) became worse at these times. He was started on Imipramine with psychotherapy and relaxation exercises. It is noteworthy that in this case the experience of torture had not been so traumatic as the shelling and death of loved ones. It demonstrates the critical factor of the victims perception and appraisal, the interpretation and meaning he attaches to the event within the context of his or her unique life situation and past experience.

Many of the psychiatric disorders developing after a traumatic experience were found to have an underlying PTSD as the following case demonstrates.

Mr. S., a 20 year old shop owner, was detained by a local militant group for two weeks, and tortured. Initially he had been hung head down with his hands tied behind his back and hit by iron bars all over the body including the head. At other times, they had pushed a pin under his nail, poured water down his nostrils and made him witness others being tortured and killed. A few weeks after release, the relations reported that he had outbursts of anger and aggressive behaviour, assaulting his relations for no obvious reason. He complained of chest pain, pain in the knees and insomnia. A few months later he had joined another militant group and had been taken for training but developed severe chest pain. They had admitted him first at the Ayurvedic hospital and later at a District Hospital. As his chest and knee pain did not improve, he was admitted to the surgical ward at General Hospital, Jaffna and then referred to the Psychiatric clinic. On mental state examination it was found the he had several amnesiac gaps for the events that had happened but remembered the torture experience quite vividly. He had frequently re-experienced the torture as if it was happening again and dreams of the scene where other detainees were killed in front of him. He had attempted suicide a month before by swallowing allary (poisonous) seeds. During his stay at the District Hospital, he had started hearing voices commenting and commanding him. In addition, he became preoccupied with fear that others were trying to harm him, spying on him and plotting to kill him. He was put on phenothiazines while counselling was also started. He made a gradual recovery. As there was no previous mental illness or family history and in view of the characteristic development of symptoms, a diagnosis of Post Traumatic Reactive Psychosis was made in his case.

Psychosomatic Disorders

The relationship between psychological stress and organic diseases like eczema, bronchial asthma, hypertension, peptic ulcer and mucous colitis is well documented and has been shown to be quantifiable (Weinman, 1987). War stress can be expected to cause a rise in morbidity and mortality. Symptoms like dyspepsia, tension headaches, backaches, dyspnoea and palpitation were common during the current period.

In some cases, the psychological stress led to more fateful consequences. Psychologically stressful life events are known to precipitate Myocardial Infarction.

A middle aged telephone operator at Tellippalai hospital who had been quite healthy, suddenly developed chest discomfort and died when his teenage children were taken in for questioning.

A patient with hypertension who had been doing quite well had a stroke when his area came under intense shelling.

In contrast, some of our patients who had been chronically ill with arthritis, backache, dyspnoea and some of a hypochondriacal nature appeared to get better during this period of stress and led a healthy life even without medication. The complaints returned with the easing of the situation.

Mrs. K. was a 60 year old obese lady who had been under continuous treatment with multiple drugs, by different doctors, for over 20 years. She experienced a variety of changing symptoms-such as dyspnoea, chest pain, weakness, insomnia, anorexia, backaches, and joint pains-that were repeatedly investigated through blood tests, X-rays, ECGs, and other examinations, all without any positive findings. She had consulted a variety of doctors, both Western and traditional who had given her many types of drugs. Her relations reported that she could not get through a day without taking some drug or other with which she would dose herself. She was quite incapacitated and would spend most of the day in bed or sitting in a chair, groaning and complaining. During the acute war when her house had come under fire, she had shown remarkable agility in escaping through the barbed wire fence. and managed for over two months as a refugee without her customary medication and complaints. Once the situation eased somewhat, her old complaints and self-medication returned.

Personality Disorders

The excessive aggressive drives of anti-social or psychopathic personality can be well harnessed for society by recruiting these individuals into a military establishment and having them vent their dangerous energy on 'enemies' of the State.

It is well established that war provides ample opportunity for sadistic personalities to derive pleasure from acts of violence, cruelty and torture on hapless victims (chap 5). When the dogs of war were unleashed on Jaffna, one got the impression that "*a band of Asuras & Rakshas had been let loose on the public*". Strangely enough after the cessation of military activities, the Jawans appeared to be innocuous human beings, with the normal variety of personality traits and personal problems. It may be that the war machine itself brings out the darker aspects of one's personality and engenders behaviour bordering on the barbaric, which under normal conditions remained suppressed. To some extent this may have been due to the releasing of the usual restraints and discipline by the higher command. This was quite clear in the behaviour of the Jawans and some officers. They killed, assaulted, looted and raped without any remorse or compassion and showed no fear of any disciplinary action from the commanding officers. In fact, they indicated that they had been given a free hand. This picture improved by December and more so by the beginning of 1988. By January 1988 the Jawans were much more disciplined, showed uneasiness and circumspection when indulging in anti-social or criminal activities. By now disciplinary action had been instituted. Identification parades were held and punishment meted out. It's interesting to note that the worst punishment from the point of view of the Jawans, was to be deported home without salary and their pension withdrawn.

The Indians were quick to realize quite early in the struggle, perhaps to the advantage of the local people, that it is easy to take but difficult to hold onto an occupied land as was shown in Vietnam and Afghanistan. They need the cooperation of the people. Thus, the '***battle for the hearts and minds'*** of the Jaffna people was launched: discipline and order was established; regular classes on public relations and Tamil language were held for the troops; rehabilitation and reconstruction work commenced; and the popular medical clinics and food distribution were started in every village. Once the tension eased, one got more insight into the personalities of the Jawans and officers. As the Jawans started to mix with the public, one perceived the more human side of their character. Despite their aggressive metamorphosis during the war, they revealed a simple earlier personality that had taken a malignant turn due to the horrendous situation they had to face. They lived simply and had simple tastes, likes and dislikes. While in battle

they had shown indomitable courage and a remarkable endurance. Another noticeable feature of their character, perhaps not surprising considering their Indian origin, was their extreme religiosity, at least externally. *Vibuthi*, *Poddus*, sacred pictures and flowers on vehicles, worship and respect at temples were very much in evidence.

One got a glimpse into their background from the small things they 'took' while searching and the expression of awe at the prosperity of Jaffna by such examination as "*What do you lack? Everything had been given to you*" (little realizing that all that they saw had been earned and built by sweat and toil off a hard and dry land). Evidently they came from the poverty ridden villages of India and the army was an opportunity for their families' advancement. But this did not detract from their straightforwardness and a down to earth outlook and an occasional kind word for the locals. When a young farmer in a frustrated outburst shouted, "*You beggars, you come and occupy our land which we have struggled to develop and order us about and destroy everything*". the soldier merely patted him on the back and said "*. . . I understand, but don't repeat it to others*". Particularly the Tamil Jawans showed considerable empathy and were sympathetic if not outrightly helpful in many difficult situations. They were very protective of women, giving kindly advice and saving them from their sexually abusive colleagues.

In contrast to the ordinary Jawans, the officers were very sophisticated, polished and suave. The army hierarchy appears to have bred an elite, true to form. They spoke good English with a typical accent, All-Indian in out-look, extroverted and sociable. Their personalities impressed and easily won over the local leading citizens. They appeared well-disciplined and in complete control of their men, contradicting the earlier "loss of control." It was quite evident that the Indian Army was a historical institution with a long tradition behind it.

Torture

In the brief period the Indian Army had been in Jaffna, it appeared that they had not adopted the more psychologically damaging torture methods. Thus, we didn't see the degree of psychological sophistication and the systematized prolonged torture of victims resorted to by the Sri Lankan Security Forces. Torture by the Indian Army tended to be short term with the specific purpose of gaining information. Although physical damage was sometimes severe such as fractures and even death, psychological sequelae was not common.

A foreman at the Paranthan Chemical Factory was taken in due to mistaken identity and tortured by being hung by the legs and beaten on the soles and back. Electrical current was passed into the sensitive tongue and penis causing severe burns and the burning end of a cigarette applied to the arms. On his identity being established the next day, he was released. Despite severe physical damage, he did not appear to have any psychological sequelae.

In contrast an engineer going to Peradeniya who was taken in by the Sri Lankan Army about the same time:

He was tortured systematically for a prolonged period, including regular passage of current through his head. Though physical damage was minimal he suffered a complete psychological breakdown and was admitted to the psychiatric ward muttering irrationally and irrelevantly, a mental wreck.

Sadly, in time, the Indian army too started to learn and apply more sophisticated forms of torture, decreasing the physical scars but increasing the efficiency with which they inflict psychological damage.

Rape

From time immemorial, plunder and rape had been considered the spoils of war. A form of '***psychopathic liberation'*** resulting in looting, rape and heavy drinking is reported to follow major stressful events (Kinston & Rosser,1974). Although the total number of rapes during the Indian army operations are unknown, They reached epidemic proportions. It has been confirmed that quite a large number of victims, ranging from young girls who had just attained, to old women well past their menopause were brutally raped.

What is said about violence in general is applicable to sexual violence. However, aggressive sexual assault has its own unique characteristics and consequences. Thus, '*rape is a violent crime in which sexuality is used to express power, anger and aggression, with a core meaning of devaluation, humiliation, sheer terror and most intimate violation of the self for the victim. What is translated to the victim is the life-threatening nature of assault, her helplessness, her loss of control and her experience of herself as an object of the assailant's rage'* (Mezey, 1985). Rape became common in the context of total war as it obtained in the months of October to December (1987), when all the customary discipline and

restraints operative in the army were released. As discussed earlier, there appears to have been a policy decision to apply terror in the face of the early losses and frustration over the prolongation of the conflict. The public was seen as too sympathetic to the Tigers, harboring and helping them against the Indian Army. Thus, terror became an instrument of control, a punishment for the lack of support and a lesson to the public. The army hierarchical structure worked to allow the Jawans to carry out the acts on their behalf, although at times lower rank officers also vented their pent up frustrations in this way. But rape was much more as it was aimed specifically at women. It was carried out with considerable brutality and impersonality, where the victims were publicly defeminised and destroyed.

Rape can be seen as a loss event for the victim where she loses her trust in others, self-respect, sense of security, chastity and virginity, social identity and become liable to secondary victimization due to social norms and values. The psychological reactions to rape have been described as a three-stage phenomena with an initial state of 'shock and disbelief' with disruption of her normal behaviour. This may be followed by feelings of guilt, self-blame, and physical complaints. If the resolution to the psychological trauma is incomplete, long term consequences include Depression (40% of victims), Psychosomatic problems, Sexual Dysfunction, specific rape-related Phobias, impaired task performance, social maladjustment and risk of suicide attempts (Mezey, 1985).

In our cultural setting, sexual violence takes on a more serious significance and has a severe psychologically traumatizing effect on the victim and her close relations, including her husband. Chastity is traditionally considered one of the supreme virtues of women, to be safe guarded with the same diligence as their life. The screams and pleading of a young, attractive girl, who three soldiers were trying to rape at gun point, still echoes in the author's ears. She fell at their feet and begged "*please brother, shoot me, but don't do this...*" Fortunately for her, her pleading got through to an officer who took pity and let her go, after slapping her. A young rape victim in Tinnavelly immediately attempted to commit suicide by jumping into a well.

Loss of virginity in a young girl even if against her will, meant that she could not aspire to marrying in our society and if already married, there is a good chance that she will be abandoned. All rape victims are socially ostracized and this usually extends to the family also. It is not surprising that rape victims were not forthcoming to report such incidents and usually swallowed the suffering and injury silently.

These incidents of rape, the lack of protection for women and the rumors that spread,

created a great fear among the women of Jaffna. The threat to womanhood was very real in the months of October and November. Most women experienced sexual anxiety and felt exposed and vulnerable. Many fled to areas they felt were safe, a large exodus reaching Colombo in December, when transport became available. Those left started acting with circumspection by following the well meant advice of sympathetic, Tamil speaking Jawans of "*wearing saris, putting poddus and staying indoors*"

At the beginning, there was lack of action by the commanders, probably because they had to maintain troop morale in a difficult situation during the first two months and rape itself became part of the army action. Later, disciplinary action was taken with identification parades and punishment, usually in the form of public thrashing and transfer to another unit. After December the Jawans were more discreet and circumspect. By 1988, the higher authorities showed much sensitivity on the issue of rape, probably due to the wide publicity outside Jaffna. They even brought in female police and paramilitary to allay the fear of the local women.

The public outcry and the wide publicity of this aspect of the Indians' occupation that gained momentum from December reflected the deep rooted feeling of insecurity and the cultural significance of this threat to our women. A young lady who had fled to Colombo, confessed that when, on her return to Jaffna in January, she saw the Indian army all over the place, a fear clutched at her heart and her immediate instinct was to get back to Colombo by the same bus. But she soon sensed, as only a woman can, that the men were now different, better behaved and disciplined.

Psychosis

In a predisposed or vulnerable individual, environmental stress may precipitate a Psychotic illness or cause a relapse in a healthy individual who had an attack earlier. In others, severe traumatic experiences can cause Reactive Psychoses which are usually of short duration, the individual recovering completely.

Due to the prevailing situation, the psychiatric services did not function for over two months, except for the few patients who 'got stranded' in the psychiatric ward at Tellippalai when the situation suddenly erupted on October, 10. Consequent to the heavy shelling of the Tellippalai hospital some patients took flight from the ward. Of these, two were believed to have been shot dead and one, who was shot through the thigh and external genitals, was brought back to the hospital for treatment.

Many patients on long term maintenance treatment from out-patient clinics relapsed due to lack of drugs as evidenced by the larger number of former patients who came for treatment after the psychiatric services started functioning.

A middle aged lady who had been doing well for over an year without drugs, had a relapse when the barrel of a gun was put into her mouth. From that time, she became restless and paranoid. For some it was the death of a close relation that was the stressor. During this period, many of our patients faced special hardship.

Some psychotic patients behaved in abnormal and suspicious ways, others wandered around during curfew hours and were taken in or shot.

A young patient had been taken in while coming to collect his drugs at the OPD clinic. He was given the so-called 'helicopter treatment' by being hung by the thumbs and beaten. He was sent to us three days later when eventually it was realized that something was mentally wrong with him.

Some incidents had a more humorous twist to them. A Schizophrenic patient who had been earlier warded at the psychiatric ward, was taken in on suspicion. He had promised to show the IPKF some LTTE. The jubilant army unit, in a convoy of jeeps and trucks, was brought by the patient straight to the psychiatric ward. The whole area surrounding the hospital was cordoned off and security measures taken. The patient then proceeded to point to one of our patients admitted there and said "*He robbed the Durghai Amman Temple, he is a top LTTE leader* and so on." When the psychiatric ward staff tried to explain that he was a mental patient probably acting under a delusion, the commander had indignantly replied*, "He is talking quite rationally, how can he be mad*?" They finally calmed down and left, leaving instructions to keep the four who had been pointed out, under confinement with no visitors or food, as '*cyanide capsules may be sneaked in with the food'*. The staff would be responsible if they escaped.

Interestingly for some Psychotic patients who had been handicapped by a chronic illness, the period of stress appeared to be therapeutic, similar in effect to shock treatment leading to normal behaviour.

Combat Psychosis

The terms '***war psychosis'*** and '***war hysteria'*** describe the atmosphere of suspicion, tension and hostility between nations, that precede or cause war. In contrast the term '*combat psychosis'* denotes a condition observed in combatants that has serious consequences to society often leading to massacres of the innocent. This term usually connotes a temporary behavioral break with reality. Perhaps "*hysterical excitement", "hysterical psychosis" or "war hysteria*" would be a more accurate term as the condition appears to have an underlying Hysterical Dissociation as the basis, occurring particularly among combatants who have been exposed to continuing and frustrating stress. Two similar conditions are described in the literature on transcultural psychiatry: "***running amok***" , first reported among Malays, denotes a condition where an individual under stress, suddenly starts running around killing anyone, who gets in his way and with whatever weapons he can lay his hands on. The second condition of going "***berserk***" derived from a phenomena found in German secret societies of the berserkers-(literally "bearshirts"), who identified themselves with a bear, in which a young man during his initiation, had to transmute his humanity by a fit of aggressive and terror-striking fury, which assimilated him to the raging beast of prey (Elcade, 1958). The lay term "*raging maniac*" is also used to describe an extreme rage reaction where the individual loses control and indulges in an orgy of violence.

An experienced physician went on record to say that during the LTTE-TELO clash in Jaffna, the militants showed the effects of being under the influence of drugs. Although he was not able to substantiate his observations, he was quite sure that the behaviour, facial expression, especially the eyes, revealed drugged effect. An educated mother, who saw her children mowed down in cold blood in front of her maintained that the soldiers were drugged. She based her conclusions on the same features described by the physician.

The militants were evidently in a disturbed state. They appeared glazed and disoriented, their grim faces darkened with eyes bloodshot and staring blankly and the movements stiff, jerky and mechanical and their speech terse.... As they moved to pile up the bodies at the road junction and set them on fire, they were inhumanely cold....like automatons carrying out a prescribed action. During the acute phase of the Indian offensive, the Jawans on occasion showed a similar picture. The facial expression, eyes, behaviour and speech were exactly the same. The overall impression was of drug effect.

It has been well known that psychotropic drugs such as alcohol, cannabis, amphetamines, cocaine, atropine like products and even opiates have been used by combatants during times of fighting to enhance their performance or reduce their psychological inhibitions

to killing. Alcohol is an initial stimulant used by angry mobs during riots, but the eventual effect is to depress the central nervous system and reduce performance and thus is not favored by the military high command. Usually, alcohol flows after the fighting is over. Alcohol use was very much in evidence in Sri Lanka during the 1983 riots and by the Sri Lankan armed forces (specially when they went on the rampage as in Trincomalee) and by the Indian Jawans. The LTTE had a strict puritan policy and were temperate. However, there was evidence of the use of amphetamines among the local militants to reduce fatigue and enhance their endurance. Prolonged or excessive abuse of amphetamine is well known to cause Amphetamine Psychosis which is indistinguishable from Paranoid Schizophrenia. However, these drug effects are not sufficient to explain the behavioral anomalies observed above. The behaviour was something specific to the war situation. Usually, it was observed after prolonged combat, after a tense and stressful situation involving deaths of comrades. Consciousness appeared to typify a narrowing characteristic of twilight states. The massacres at Anuradhapura, whole villages in the East, Killinochchi railway station, Kokkoddicholai, Valvettithurai and so on by all the parties to the conflict have manifested similar behavioral patterns. There have been examples of men under tension in camps going 'berserk', killing their comrades, officers and then themselves. The movements, expression and speech suggested rage, fury and loss of control.

Childhood Disorders

Children's reaction must be understood within the context of the family. Their reactions are a function of the way in which reality filters down to them, so that they mirror their parents' reactions rather than directly relating to the event. The major fear at all ages is separation from parents. If this does not occur, and if the parents cope with the situation, children show little awareness of danger and minimal anxiety. However, if the parents react with fear and anxiety, lose control and discipline, or the child's regular and ordered world is changed frequently, or if the parents themselves are missing, the child will commonly present with disturbance in physical function (such as enuresis, functional diarrhoea), emotion (such as crying spells, withdrawal), or behaviour(such as clinging, temper tantrums).

A dental surgeon's eleven month old son developed during this period a chronic diarrhoea which did not respond to the usual medications. Their home had come under heavy shelling and they had fled from place to place as shelling and gunfire started up wherever they stayed. The parents had experienced considerable anxiety for the safety of their two children as they moved about. The diarrhoea would stop and start up again, this continuing throughout two months. It stopped spontaneously when the family returned to their home after some normality and quiet had been established.

Parents reported that children were having disturbed sleep patterns frequently awakening after nightmares and night terrors. Children were found to wake up screaming in the night, drenched in sweat. Parents have had to stay with a child when he falls asleep, and be by his side whenever he awakens.

All children are not uniformly affected by the stress. It was noticed that after showing some initial fear and clinging behaviour due to exploding shells and rattle of machine guns, some were quite undisturbed and took things in their stride. At refugee camps, children were found to be playing, making a huge racket, enjoying themselves, despite all the tension the adults were going through. Others reacted badly showing anxiety and other emotional disturbances even after things had settled down or the family had moved to a safer place such as Colombo. To some extent the child's reaction was dependent on the severity of stress gone through and the reactions of the parents. Children of parents who were tense and anxious showed anxiety and fear. When parents themselves are disturbed by the ongoing war, they will not be able to provide the nurturance and support the child desperately needs at this time of crisis. In addition, as children interpret the events happening around them by the reaction of their parents, and their immediate and extended family, pathological reactions in the family are easily transmitted to the child. The family unit is an ongoing system, where equilibrium is maintained through complex interactions in between the members and between the family and the outside world. The child is completely dependent on a stable family system that is in equilibrium within itself and with the outer community. When catastrophic events disturb this delicate equilibrium, the most vulnerable is the child who will manifest with various psychological problems depending on his or her age, stage of development, traits, family dynamics, etc.

Master H., a four year old child was brought by the mother to the psychiatric clinic with complaints of frequent crying spells and clinging on to the mother. The child never lets his mother out of his sight for more than a few minutes, becoming restless and anxious when she tries to leave and clings onto her tightly when she returns, not allowing her to continue her normal work. He was reported to scream at the sight of strangers and was extremely sensitive to loud noises. He was reported to be unfriendly, refusing to go to nursery or mix with anybody other than those from his own household. He was quite attached to his brother but becomes frightened and runs to the mother when the brother tries to play any games using war toys or in any way resembling the war. The child was reported to frequently say he is 'frightened'. At nights he gets up from his sleep screaming. According to the mother the child's development was normal up to 10 months, but since then the milestones have been slightly delayed, the child walking and talking later than normal. On taking a detailed history, it was revealed that the child had undergone a severely traumatising experience when he was 10 months old. At that time in October, 1987 when their neighbourhood came under intense shelling and later gun fire, he had been separated from his mother who had gone on a visit to a distant village intending to return the same day. But due to outbreak of the war, the separation had lasted for 10 days. During this time the child, though well looked after by the grandparents, had been restless, constantly crying, refusing oral feeds, slept little, awakening frequently and developed a diarrhoea that did not respond to medical treatment. The grandparents, with whom he was, also had shown intense emotional reaction with screaming, panic and flight to refugee camps. The mother had made frantic efforts to rejoin her child but did not succeed in finding him for 10 days due to the intense fighting. On reunion the child had leaped at his mother and clung onto her, thereafter refusing to be separated. His diarrhoea subsided, he began to eat, drink and sleep well but the family continued to have hardships-they remained refugees for over a month, amidst the shelling, shooting and fighting all round. The mother herself developed florid Post-Traumatic Stress Disorder. When the fighting had started, she had been separated from her child. She became distraught and inconsolable, insisting ongoing out, looking for the child. At first opportunity she had frantically searched from place to place though intense fighting was still in progress. She witnessed death and destruction everywhere but had persisted, pleading with the few vehicles like lorries (trucks) to take her, telling them of her plight. It took her ten days to find the child during which she was always afraid that something may have happened to him. Even after that the family continued to experience hardships and trauma as refugees caught in an ongoing war. The support of the husband was not

available during this crucial period as he had migrated to Canada ten months previously. The family finally fled to Colombo where they stayed for over an year. The mother began to re-experience the traumatic events as intrusive images and memories during the day time and night. She had been chronically anxious with disturbed sleep and appetite. She was hypersensitive to loud noises and became disturbed on exposure to stimuli resembling the original events. For example, on seeing a lorry she was immediately reminded of her desperate searching for her child and she used to go into a panic. The family often talked about these events with much emotion and the growing child used to listen attentively, in time repeating them as if he had experienced them first hand. It is probable that he learnt about 'fear' and the accompanying emotional and physical states from these stories. Subsequently he used to frequently say he was afraid. Though the mother's symptoms had gradually subsided, the child had begun to show developmental delays, severe separation anxiety, fear of strangers, social withdrawal and regressive behaviour. As his condition did not improve as he grew older, as the family had hoped, they finally decided to consult a specialist, 3 years after the original event. Significantly the 5 year old elder brother who had not been separated from his mother during the critical period of extreme stress had remained normal. Art and play therapy with low doses of Imipramine was given to the child while counselling was begun for the mother. Due to the high probability of permanent scarring in the developing personality of the child, it was recommended to the High Commission that the family be allowed, on humanitarian grounds to join the father in Canada where facilities for adequate treatment by a child psychiatrist will be available.

Traumatized children, who are often unable to express and ventilate their feelings verbally, show a compulsive tendency to work through their experience through repetitive play, storytelling, drawing and dreams. In a more supportive and relaxed atmosphere, it is postulated that the child develops a sense of mastery and control and eventually comes to terms with the experience. However, when the experience has been too overwhelming, rendering the child especially helpless, the traumatic re-enactments may be compulsively repeated without the successful retrospective mastery (Raphael, 1986). The child may then continue to show symptoms like recurrent nightmares, emotional or conduct disorders.

Delinquency has been found to be a common complication of exposure to war conditions (Lewis, 1942). It is also likely that repeated exposure to violence-a family life ruled by terror and frequent disruptions, and a society in a continuous state of disequilibrium-where, acceptance and praise is given to acts of violence and recognition to the instruments

of violence, the child quickly learns the way of violence. This change is quite evident in the Tamil society. Thus, the child today is quite familiar with all the military lingo, and shows preference for war toys and games which is encouraged and reinforced by parents and society. A short time ago when the author presented a child with an 'educational toy' for his birthday, his mother, a lady doctor protested saying "*What good is that, you should have brought a toy machine gun*". When a child was given some building blocks, she immediately proceeded to build a 'chain block' (tank) and a helicopter with 'guns' sticking out showing clearly how preoccupied she has become with war. This is not helped by the present trend of involving and recruiting younger and younger children into military activities, at an age when they cannot quite realize the meaning of their action or its long term consequences. When they act impulsively for kicks and the joy of action it portends ill for the future.

Family

The war has affected the functioning of the family unit in many ways. From the loss of one or both parents, separations and traumatization in one member, pathological family dynamics can adversely affect each member, particularly the children. A common situation is where the father has been detained, 'disappeared' or killed but the family members are not sure of his fate. They are caught in a 'conspiracy of silence' where further inquiries may lead to more problems for the father were he still alive and the mother may not be able to share the truth with the child. The child then presents with behavioural problems. Having the mother share her fears with the child can be helpful.

As a general rule, efforts should be directed at keeping the family together and improve its functioning. However, problems in children can be a reflection of pathology in the family where the parents may themselves be traumatized and the family dynamics may bring out the problem through a child as the following example shows.

An 11 year old girl was referred to the psychiatric clinic due to episodic fainting attacks for the last month. The paediatrician had not been able to detect any organic abnormality. Her class teacher had observed that just before attacks, she said "why did they kill my sister" and then complain of numbness of head before fainting. The history revealed that her sister had been killed by a shell piece 5 years ago. At the time the whole family had taken refuge in the front house due to intense shelling in the area. The father was carrying the youngest sister on his shoulder while the older one was in his lap. The girl in the lap

was struck and the gruesome death in a pool of blood had taken place in the presence of the whole family. Afterward, the family endured several hardships, including displacement to a refugee camp, the killing of the grandfather and grand-uncle, and the father's detention, followed by his eventual release.

The father developed PTSD with re-experiencing and neurotic symptoms, particularly Somatization (11 somatic complaints). The mother too developed PTSD with severe Depression and Anxiety. She lost interest in all activities, developed crying spells and was withdrawn from all social activity. She dragged on for the sake of the other children and often repeated "the same thing should not happen to them". She became very anxious at any noise particularly the sound of a helicopter or plane, when she would gather the family and run to a bunker. If they are not at home, she would become very frightened. At other times, if they are late in returning, she would anxiously wait for them at the doorstep.

As a family they avoided going to or looking at the place where the sister had been killed. They all refused to talk about the sister or the circumstances surrounding the event. Persistent probing revealed amnesiac gaps in their recollection of significant details. The general impression was that the whole family had repressed the tragic memory so as to continue living. But this was manifesting itself as different symptoms in each member. Treatment had to involve the whole family. The individual problems of the parents had to be addressed and then the family dynamics that avoided dealing with what had happened to the child that had died had to be brought out in to the open. Slowly the family came to accept the death and the child recovered.

Conclusion

The Jaffna man will not easily forget those October days when India fought bitterly with the Tigers for control of the peninsula. The events of the war will be imprinted permanently in their minds. For many the trauma was too much, and they manifested with a variety of reactions that are recorded here. When we try to do something for them, the need for a peaceful environment where healing can take place becomes very clear. However, the long-term future of the children growing up in this atmosphere of violence and destruction causes great concern. In particular, the need of children orphaned by the war for a warm nurturant and peaceful upbringing free from the indoctrination of hate is something our society owes them. Somehow, we have to break the cycle of making them the future soldiers.

REFERENCES

1. Elcade, M. (1958). *Birth and Rebirth*, Harper, New York, quoted by Fromm, E. (1960). Psychoanalysis & Zen, Unwin, London.
2. Kinston, W. & Rosser, R. (1974). *Disaster effects on Mental State and Physical state*, Journal of Psychiatric Research, 18, 437-56.
3. Hoole, M.R.R., Thiranagamma, R., Sritharan. K., Somasundaram, D.J. (1988), *Broken Palmyra.* Harvey Mudd College Press, Calfornia,USA.
4. Mezey, C.C. (1985). *Rape-Victimallogical and Psychaiatric Aspects*, British Journal of Hospital Medicine, March 1985.
5. Lewis, A. (1942). *Incidence of Neurosis in England Under War Conditions*, Lancet, Aug. 15,1942.
6. Raphael, B. (1986). *When Disaster Strikes*, Hutchinson, Australia.
7. Weinman, J. (1987). *Psychology as Applied to Medicine.* Bright, Bristol.

My Soul Weeps[1]

Memories of torture and suffering crowds my thoughts,
Death cries of killed loved ones echoes in my ears-
Victims of the atrocities of a demoness regime-
Keeps reverberating continuously in my mind.

Was it a crime to be born Tamil?
Was it a crime to love our homeland?
I fail to comprehend.
With a heart hardened by pain and trauma,
I survive here today, burdened by memories.

They came, envoys of demoness in white vans[2]
Bound me with explosives,
Forced me to lie beneath their boots,
And struck me relentlessly,
Mocking me with a chorus of violence, kottiya[3]

For what crime was I beaten?
Why was I subjected to this?
I knew nothing.
Thrown into a dark, airless cell,
Kicked and locked away,
I was left to endure the silence of a graveyard.

The agonized moans of others filled the void,
Each scream crashing against my eardrums,
Reminding me that in this place,
There was no dawn, only endless darkness.

Time had lost its meaning.
Pain became the only reality.
To them, we were mere playthings,
Tossed and beaten at their whim,
Until our eyes swelled shut from the brutality.

In that filthy, suffocating space,
The stench of blood, excrement
and urine surrounded us.
We were left in isolation,
Unable to speak to one another,
Stripped of our dignity and our voices.

At the peak of their merciless assaults,
Our bodies split open,
Blood and pus oozed from our wounds,
Leaving us on the brink of unconsciousness,
With death as our only escape.

Hung upside down, stripped naked,
They shoved sand filled S-lon pipes
into our bodies,
Stuffed soil into our throats
through rubber tubes,
Crushed our ankles with brute force,
And laughed at our screams.

Once we collapsed,
they revived us with cold water,
Only to continue their abuse,
Breaking our spirits,
Turning us into lunatics.

Men and women alike,
Regardless of gender,
Were subjected to
unspeakable sexual violence.
The chilling cries of victims
Became a routine nightmare
in the dead of night.

There are so many pains I wish to voice,
Yet so many that words cannot express.
With tear-filled eyes, I ask-
What was my crime?
Other than being born Tamil,
What did I do to deserve this punishment?

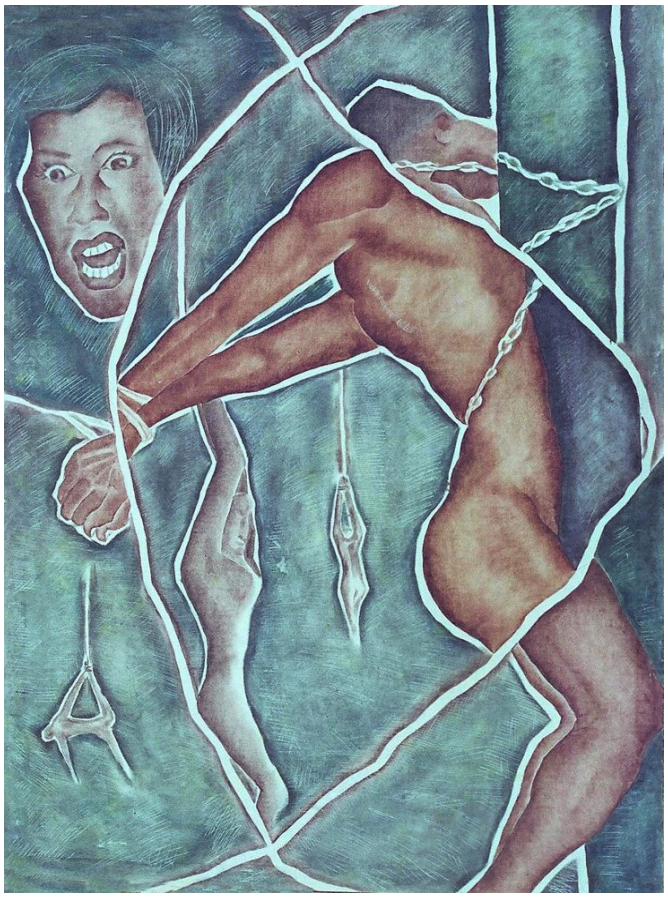
-Bhavani
Translated by Dr. V. Anavarathan

[1] A poem by a female torture victim
[2] Persons were abducted or arrested by unmarked white vans during that period to often be tortured, disappeared or killed and bodies exhibited publicly.
[3] Tiger in Sinhala

CHAPTER 7

THE PSYCHOLOGICAL AFTER EFFECTS OF TORTURE

By Dr. Anna Doney



- Pugazhenthi (telibrary.com)

"Torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason."

-The Declaration of Tokyo, (World Medical Assembly, 1975)

INTRODUCTION

Torture has profoundly traumatic and lasting effects on its survivors, and indirectly on the communities from which they come. A country in which torture is widely practised is left with a legacy of thousands of men and women who have been emotionally and physically broken. Each of those torture survivors also has a family that has been cruelly disrupted, and many will pass on elements of their distorted life pattern to their children. In countries where torture is widespread the medical, psychological and social rehabilitation of survivors becomes a pressing problem. Unfortunately, because torture usually co-exits with political instability, repression and other forms of organised violence, such

rehabilitation is extremely difficult. Also, since torture is never officially sanctioned, it is not normally officially recognised that the survivors of torture require special remedial care. Worse still, without a favourable change of government or regime the fact of torture can become a carefully guarded secret, thus preventing the open running of rehabilitation programs.

Much of the published research on rehabilitation work with torture survivors has come from centres in Western countries which deal with individuals who have fled as refugees. These people have the added trauma of exile to face, but are relatively lucky in that they are relieved of the extreme anxieties they would have in their own violently disrupted communities. Only a small proportion of torture survivors manage to find their way into the security of exiledom. The majority struggle on with their horrific memories and damaged bodies in the absence of specialist supportive care, facing the uncertainties of violent action in their communities and plagued by the fear of re-arrest.

It is very important that the specific needs of torture survivors who return to their own communities are studied. These individuals, newly released, often have immediate need of medical attention. In many countries there may be no access to a doctor let alone a specialist, in any case some ex-detainees may believe that their injuries are not curable. Others may not have the will or the money to make the journey to see a doctor, or to pay for the medical bills incurred. The trauma of torture often leads individuals to become depressed, unlikely to make repeated and possibly dangerous journeys to do the rounds of busy hospitals to seek specialist treatment for their multiple ailments. Doctors on the other hand are often confused by the extent and chronic nature of the symptoms they see in torture survivors. They dismiss many of the symptoms as being psychosomatic and after referring the patient to various departments finally give up and discharge the case as untreatable or in need of psychiatric care.

Thus, the gulf between the needs of the torture survivor and the available existing resources in their community must be bridged. But more than this, it is crucial that sensitive programs of intervention, referral, occupational training and rehabilitation are set up. Medical and psychological help should be integrated for these victims of violence who have such combined needs.

Furthermore, severely traumatised individuals should not be expected to make long and sometimes perilous journeys to clinics, unless they have been referred for specific needs. Medical and psychological support should be made available in rural areas, together with facilities for training programs and help towards the setting up of support groups for torture survivors, their parents and spouses. If specialist workers are not

available to work in local communities, then at least a mobile screening service should be introduced. In this way, target groups can be identified who require specialist attention such as for example, surgery or orthopaedic or psychiatric care. These groups can be briefed in advance about the particular needs of torture survivors.

The Breaking of Individuals and communities

In writing this chapter it is the author's aim that the reader will become aware of the profoundly damaging psychological after-effects that torture has for the surviving individuals. Although it is the trauma to the individual that concerns us most here, we must also recognise that as all detainees have parents, families, economic and social roles, the traumatic effects of systematic torture upon communities can be devastating. Torture although directed at individuals, is felt as a weapon turned upon an entire society. Furthermore, the trauma of torture echoes on through generations, since the cruelly distorted life pattern that torture survivors suffer has direct and disturbing effects on the children of the family.

Many readers when hearing the word 'torture' may think of an interrogation process which has the aim of gaining information or extracting a confession. However extreme the action of the torture, torture itself can be given a rationale. Helen Bamber (1988) of the Medical Foundation in London writes,

"*Isolation, humiliation psychological pressure and physical pain are means to obtain information, to break down the prisoner and to intimidate those close to him or her. The torturer may be after something specific, like a signature on a confession, a renunciation of beliefs or the denunciation of relative, colleagues and friends who may in turn be seized, tortured, and if possible, broken.*"

The interrogation aspect of torture is often highlighted, as in, for example, the World Medical Assembly definition cited at the head of this chapter. This most obvious interpretation of torture is adhered to in an attempt to 'understand' or give 'reason' to this dark side of human nature. It is very difficult for the human mind to grasp the enormous savagery that can occur between people. Torture makes a grotesque mockery of all that human nature aspires to; the achievements of great civilisations, the wisdom of our philosophers and religions, and the perfection of love between a mother and child. The cruelty and senselessness of torture is impossible to understand, so we resort to limited and therefore comforting explanations. It is easy to view the torture victim as one who is trying to undermine the stability of a society and who, furthermore, is sealing his own fate by refusing to yield information helpful to the security forces.

The torturer, on the other hand, can be seen as an unfortunate upon whom the burden has fallen to gain information or as someone who is 'just following orders'.

The truth of torture is usually very different from this interrogation process. The scale on which torture takes place, the arbitrary nature of arrest, and the often humiliating and extreme nature of the injuries all suggest that 'information gathering' is only a small part of the intent. Undoubtedly extraction of information is an important motivator, particularly where sophisticated intelligence gathering methods are lacking. However, it is through the subduing of population with terror that torture has its greatest effect.

Torture is often resorted to in countries like Sri Lanka, where militancy is simply an expression of a popular uprising. In such conditions it is easy, once involved in acts of violence, to simply go-to-ground and vanish against the background of their society. The definition of who is and who is not involved in violence becomes one of degree, and those whom the security forces are seeking are little different from the ordinary man in the village. Torture becomes a coarse grained tool to sift through a community in the hopes of forcing a confession of involvement from someone, together with the identities and location of their contacts or weapons. There are always many 'innocents' who also get caught in the net. Those who 'talk' under torture may actually know very little, but in a desperate attempt to attain release, may give false information or point out at random in identity parades. In any case, the accuracy of the information gained from individuals in deep pain, shock or in a dissociatory state is dubious, and has indeed been questioned on these grounds alone by military forces around the world. Many ex-detainees suggest that they were given the 'label' as justification for their detention by the arresting force, and subsequently this misinformation became extremely difficult to prove incorrect. Torture survivors certainly believe that the treatment they received was actually meant as punishment, both to themselves and indirectly to their community. Proof of this, they say, is that the torture they received was not only arbitrary, but became far worse when their captors suffered a loss somewhere in battle outside the prison.

The practice of torture, regardless of its rationale, certainly has the effect of striking terror into a community through profound terrorisation of its individuals. In this study reported here, all those who had been detained had also been tortured. Thus, torture becomes a routine procedure within the whole detention process. The implied threat to all in the community leads to a silencing of the political voice of that community. The detention of individuals on the slightest suspicion during, for example, cordon and search operations and their subsequent torture, has clearly terrorised particular communities. On balance it probably deters some young men from joining movements or speaking out against

Government policy. However, the sense of outrage that crimes against humanity produce in people, spur others on to fight committedly against those whom they perceive as oppressors.

When torture is found as part of organised violence it always co-exists with numerous other human rights violations and arises out of precedents. Torture is therefore usually associated with other major features of political instability such as warfare, political unrest or conquest, impotent or corrupt legal systems, fleeing refugees, political imprisonment and disappearances. When used as a tool of political repression and control, organized violence can be embedded into the very system through laws that legitimize and enable torture. In Sri Lanka, provisions in the Prevention of Terrorism (PTA) and the Emergency Regulations (ER) provide a ready context for torture to take place (Amnesty International, 1985, 1996b). It is possible for the state forces to arrest and detain an individual for extended periods incommunicado without producing them before courts or informing relatives, in locations and conditions entirely at the discretion of the forces. In addition, they were allowed to dispose of bodies without inquest or post mortem. They also enjoyed impunity from prosecution for human rights violations. So far, no perpetrator in the Sri Lanka forces has been punished. In fact, some have been transferred with promotion (see Chapter 2).

Because torture is associated with other forms of mass violence, the individual survivor of torture often returns to a society which is in itself traumatised, and re-arrest becomes a distinct possibility. Ironically, it is sometimes the ex-detainee's extreme fear of men in uniform that leads to their re-arrest. Someone in the security forces doing a routine check becomes suspicious when he sees that the hand holding the identity pass he has asked for is trembling and the face is panicky, pale and sweating. Many ex-detainees have recounted how they became so terrorised when going through one of the numerous road checks that they aroused immediate suspicion.

There is often real validity for the extreme anxiety, fear, social withdrawal and so on, suffered by torture survivors who return to their communities. This fact has led those interested in the psychological sequelae of torture to examine the relevance of the clinical category of 'Post-Traumatic Stress Disorder' for these survivors. An 'Inter Trauma Stress Disorder' category would better reflect the actual circumstances of hundreds of thousands of torture survivors around the world.

A small proportion of torture survivors manage to travel to other countries in the hope of settling elsewhere as refugees. These individuals exchange the experience of extreme insecurity in their own countries for that of the discontentment and loneliness of a being

a stranger in a distant land. Such an individual faces, among other challenges, navigating the asylum process through an often hostile bureaucracy in an unfamiliar language, enduring separation from family and friends, and coping with joblessness and the resulting economic hardships. In short, the survivor of torture struggles to find the harmonious and stable conditions needed to restore mind, body and spirit.

The use of torture as a legitimate policy of government is not officially sanctioned in Sri Lanka, as the government officially recognises many of the international and UN treaties, Conventions and Declarations against torture. Therefore, the presence of torture and its common counterpart "disappearance", suggests pervasive corruption or inadequacy of the legal system or its cynical manipulation by a government. Unfortunately, in Sri Lanka, not only the State forces but the various Tamil militant organizations, including the LTTE, and the Indian Army (IPKF) have all practised a range of forms of torture.

Since the torture process commonly involves inflicting extreme pain over a prolonged time period, it often carries an individual close to death. The torturer holds complete power and there is nothing the tortured can do in defense either by using strength or intellect, or often even by giving the required information. Some cross the thin line between living death and actual death, succumbing to brain damage, heart failure, ruptured organs, or drowning as water, vomit or blood fills their lungs. Others may be claimed by diseases which spread rapidly in the often cramped and unhygienic conditions in the cells. Bruised, bleeding, burnt and dislocated bodies present potential embarrassment for the torturers whose first wish is to hide their work. The formalities of registering the cause of death require entering the legal process which, even when corrupted, may eventually lay the torture open to questioning. Often instead the deceased is simply disposed of and becomes untraceable, a "disappeared" person to the anguished relatives. The captors claim no knowledge, or say alternatively that the prisoner escaped, was released or even that he was shot while attempting to escape.

Because of their brutal treatment and the often unhygienic environment, detainees frequently are in need of medical attention. A doctor is sometimes the only outsider that a detainee sees. It is of interest therefore to note the special role that medical doctors have in any discussion on torture. Doctors and particularly army doctors are given access to detainees for a variety of reasons. It is not usually the wish of the captors that a detainee should die under interrogation. Doctors are, therefore, required to verify, for example, that detainees have strong hearts or are generally robust. Sometimes a victim who has been undergoing torture may be brought for treatment, such as infected wounds or fractures. Once they recover, most probably the torture process will continue. In this situation, the doctor faces a moral dilemma. To refuse would mean that the victim

continues to suffer what can be medically alleviated. But treatment so that he recovers means the torture goes on. Sometimes the person later dies. The doctor can risk making a protest or try to keep the victim in hospital under one pretext or another. But this is very risky business. Working in totalitarian situations usually preclude any form of resistance or disagreements with the authorities. Doctors are also required to give general treatment to those in detention lest the authorities be accused of medical negligence. In a few cases doctors and medical personnel have been directly implicated in the process of torturing, either by administering mind disturbing drugs, advising on suitable methods or actually taking part as an accomplice by using their special medical knowledge. The ethical standing of doctors who enter the torture process in this way, either willingly or under threat, is the subject of great debate and is being researched by, amongst others, the Danish RCT group and Amnesty International (1996a).

Doctors often also play a special role in the life of the newly released detainee. It is usually the doctors in civilian hospitals and clinics who are the first people to observe and understand the wounds on the bodies of ex-detainees. It is because of this close contact with the results of torture, their sworn medical ethics and also their considerable weight in society, that doctors have a unique part that they can play in the prevention of torture. Doctors working under the most difficult circumstances of war are to be greatly respected and it is recognised that their ultimate aim of healing the sick and wounded is so easily jeopardised. Nevertheless, it is true to say that doctors could be a very effective force in working towards a humanitarian society in which torture plays no part, if they used their position and influence available to them. This was to some extent possible in Northern Sri Lanka where medical personnel were able to build up a case against torture, particularly against using adolescents as torturers by showing the psychological ill effects on the torturers (see Chapter 5).

In the next section some description of the manner in which arrests commonly take place are given. Some of these descriptions are more relevant to arrests made where activity has been most intense, however, arrests in less affected areas follow similar patterns. The manner in which detention of individuals takes place has also changed little with the passing over of authority between the Sri Lankan and Indian armies.

How Arrests are Commonly Made

Part of the insecurity that torture introduces into a society arises out of the manner in which arrests are made. Mass arrests understandably keep a whole community in a state of fearful apprehension, particularly since search operations occur at random with no warning.

Mass Arrests

During cordon and search operations, large numbers of civilians are detained when military personnel block off an area and round up suspected militants. These operations are often carried out at random, generally in the early morning hours, which maximises the intrusion and helplessness felt by the community. Announcements over loud-speakers call up all men (and sometimes women as well) between the ages of 14 and 40 to gather in a common place such as at a road junction or a place of worship. They may be detained there for many hours, kneeling or standing in the sun. The military look for clues that suggest that a man is in militant training, such as a muscular physique or roughened skin on the elbows and knees. Shell blast injuries also arouse immediate suspicion of involvement in militant operations. Where there has been some specific militant activity such as an explosion or a shooting, and particularly if army personnel have been killed, mass arrests of innocent bystanders are more likely.

The military often use a previous detainee who they believe will be able to pick out the militants from amongst the gathered men. This is usually a man who will, most likely, have been through torture and threatened with further torture on failure to identify other militants. This informant will have a sack over his head with two eye-holes cut out to mask him from view, and he will point out people from those paraded in front of him by nodding his head (called in local parlance, *'thalai addi')*. Someone described being in an identity parade and being very moved when he saw that the eyes peering through the sack were those of a woman and that she was crying.

On other occasions all the men of an area will be driven off in lorries to an army camp again to be paraded in front of a hooded informant. Those picked out of identification parades are detained for interrogation and since the army has no other intelligence on supposed militant activity, these individuals are generally tortured as well. An individual may be released after days or weeks if no incriminating information is forthcoming from either that individual or from his neighbours picked up during the same mass arrest, and further masked identity parades fail to cross reference him as a militant. However, many individuals picked up in this way remain in detention for month or several years. Once in the system there tends to be long period of at least several months or more before a person is freed: this is possibly to allow the signs of wounding to heal before release.

Obviously cordon and search operations instill a deep feeling of peril and insecurity into a community since during these persons are picked up and detained where methods of torture can be extremely harsh. The detainees find themselves under pressure to make the army feel that they are getting results as not to prolong the torture.

The following statement by a torture survivor illustrates this:

"I lost consciousness and was splashed with water. I insisted I was not a terrorist and did not know any who were either. So they brought in the man who had earlier identified me in a parade. They asked him why he had pointed me out. He said that it was to avoid another beating himself-so they beat him again and later I heard that he had died".

Individual Arrests

Specific information may be given in detention about a person and this will lead to his house being surrounded and a search being mounted for his capture. During this process relatives may be threatened. Alternatively, any person found in possession of proscribed literature from the armed groups or who have helped them in any way (with donation of food or money for example) will be taken for questioning and torture.

-Child Soldier (Vannai Kaaddunkal Siraku Vrikka)

A Survey of Torture Survivors in Northern Sri Lanka

MATERIAL AND METHODS

A number of medical personnel and some individuals interested in psychology and counselling carried out a survey of the physical and psychological sequalae of torture. A total of 158 men and 2 women were surveyed in their home town and villages in the north of Sri Lanka.

The survey was carried out in response to a newspaper call in 1988 which requested medical help for the ex-detainees in Vavuniya. The newspaper item said that 487 ex-detainees had formed a group in Vavuniya and that 80 of them required urgent medical attention. Shortly after this appeal a few medical students and counsellor/psychologists went to the area to assess the needs of the ex-detainees. In an initial pilot survey, it was found that although many needed medical attention almost all had chronic and distressing emotional problems. The physical, psychological and social problems of 160 of these ex-detainees were recorded in detail on a longer, second visit a month later, in which a group of about 15 medical students, a few doctors and a counsellor /psychologist stayed in the area for over a week.

The survey which was unique assessed the main medical, psychological and social needs of this group and sought ways in which to continue to support such a rural population with the greater but distant resources available. It is hoped that the results of the survey and development of the intervention methods which were tried out during the survey, will help in the rehabilitation of the over ten thousand other ex-detainees who have returned to their villages and towns.

Details of Methodology.

In the initial pilot study 25 ex-detainees were seen and their medical and emotional problems assessed. Following this it was decided that much beneficial information could be obtained if questionnaires were given to a much larger group of ex-detainees. From this it was hoped to gain a profile of their common physical and psychological complaints, and to work out an appropriate response to their needs.

Questionnaires requiring responses on twenty categories. Questions were given out about a week in advance of the actual visit of the medical/ counselling teams. They were asked to fill the questionnaires, with simple yes or no responses, either by themselves or with the help of their relatives. In this society, as in most cultures, there is a strong social stigma against being thought of as having a mental problem. Consequently, the ex-detainees were simply told that they could see visiting medical teams who were visiting their area if they so wished. For this reason also, the questions dealing more with the 'psychological' aspects on the questionnaires were mixed up with straight forward questions about physical health.

When the ex-detainees visited the makeshift clinic, they were seen one at a time in privacy. Their physical problems were discussed and treated and if they raised issues

relating to their detention, emotional or social life the medical students and a counsellor or doctor listened with active listening skills and gently encouraged them to speak further.

Each ex-detainee was seen by one of three groups each consisting of two or three medical personnel (who were trained in basic counselling techniques and some psychiatric medicine) and one counsellor. While one of these survey teams was stationed at a town location, the other two groups went to the surrounding villages. Ex-detainees, or 'clients' as they were called, were seen either in the hospital in the town, or in rural clinics in the surrounding villages.

Out of the approximately 200 questionnaires that were given out 160 were returned by people who presented themselves to the medical teams. In this way the survey sample, being self-selected, may not have been totally representative of the population of ex-detainees of that area. The less physically and mentally traumatised may have not felt it necessary to turn up and the most severe cases may not have been able to come. Nevertheless, the survey teams were satisfied that they had seen a good representative sample of the total population.

Most of the ex-detainees were between 21 and 25 years old, although the overall age range spanned from 16 to 66 years. Female ex-detainees are not nearly so numerous as males and probably many had not joined the predominantly male 'self-help' group that had originally put out the newspaper item requesting medical help. For these and may be other reasons relating to the perceptions of the female role in society, only two of the one hundred and sixty given medical interviews were female.

Most had been released approximately nine months before the date of the survey, but the range of the period since release to that of the medical interview varied from one day to just over five years. The average period of detentions was thirteen months, the range being from forty-two days to five years. They had been detained in different prisons, army and/or police camps and detention centres around the island. The most common and notorious were Boosa in the deep South and Welikade near Colombo.They had been released under the terms of the Peace Accord.

During the medical interview the ex-detainees were given gentle encouragement to talk about their feelings towards their experiences and their life in general. The medical/counselling teams had the returned questionnaire which at a glance gave some information which could be used as a starting point for conversation. While the ex-detainee was speaking the various physiological concomitants of the emotions raised could be observed. It was hoped that the client's unique experiences and most distressing problems were

brought up during the medical interview. For this purpose no time limit was set to the interview, though unfortunately the pressure of people waiting to be seen meant that the longest interviews were 45 minutes and most were about half an hour.

Where on the spot medical advice could be given, this was done. Others were given the opportunity of referral to see specialists. On the spot psychological help was, of course, far more difficult and often outside the training limits of the medical/counselling teams. However, it was felt that by simply listening and showing understanding, some concrete support had been given. The clients by describing their experiences were giving vent in a small way to their frustrations and perhaps the fact that an outsider was listening was of benefit to some. Their current life conditions were discussed and the new meanings they gave to their life were explored.

The brief medical interview also gave an opportunity to discuss the value of relaxation and the possibility of sharing problems with someone such as a relative. Issues such as guilt and mistrust could be related back to their prison experiences. Many had not realised that their specific complaints were common if not universal amongst torture survivors. Others who felt they had a 'mental' problem found out that some relief was available through breathing technique or physiotherapy. Perhaps the greatest ultimate benefit that the survey visits gave, was that it showed the ex-detainees that in uniting in a 'self-help' group they had brought help to their villages and paved the way for further alleviation of their suffering.

At the end of the time spent with the client he or she was given medication with the authority of the doctor if this was felt necessary. Only simple drugs could be given as most of the clients had no easy possibility of having drug treatment supervised by a doctor. In a few cases minor tranquillisers and sedatives were given to those who clearly needed this medical intervention. Iron, vitamins and dietary information was given to correct nutritional deficiencies. Worm treatment was given to some clients and common infections were treated with antibiotics and anti-fungal agents. Pain killers were given to many and rudimentary physiotherapy exercises were demonstrated.

The clients who needed further examination and investigation were referred to the local D.M.O. (District Medical Officer). The purpose of all medication was carefully explained, and efforts were made to not encourage the client into seeing themselves weak and sickly, following their treatment in prison. It was found that some of the clients had been given placebos such as vitamin B complex by other doctors who had been unable to 'cure' their ailments.

Finally, before the client left, a moment was taken to check through their questionnaire

responses and they were asked for clarification if necessary. When the client left the room the medical/ counselling team made joint notes on their observations and findings on a separate sheet and attached it to the questionnaire.

RESULTS

The Common Methods of Torturing Received

The treatment received while in detention was not requested during the survey, however most of the ex-detainees related their experiences to a certain extent while describing their physical, emotional and social problems. Of course the nature of their physical injuries and conditions was directly related to the particular form of torture they had been subjected to. The methods of torture were also found to have great impact on the later manifestation of psychological problems. For this reason a brief account of the different torture methods described by ex-detainees are recounted.

The torture methods used varied depending upon the particular area the person was detained in. There were also differences of style and degree used by the various armies, security agencies, anti-state and non-state groups. It also seemed that techniques developed, or introduced to one area were learned by others and spread in particular ways across the country. There have been suggestion that foreign military personnel and mercenaries have been involved in the teaching process.

To a certain extent it is misleading to categorize torture methods into physical and psychological, since every physical scar carries an associated emotional scar. However, there are forms of torture in which the body of the detainee is not touched and his mind or will instead become the focus of the captor's attention. On many occasions ex-detainees reported that they could personally endure any amount of pain, but they could not endure to watch the torture of another person. The torturers often used this fact in breaking a person and forcing information out of him.

Common Physical Methods of Torture

Typically, all the clothes of the detainee are stripped off. Then he is beaten with clubs, firewood, iron rods, or a PVC pipe filled with sand or cement. He may be kicked with boots or lashed with a waist belt. He is beaten all over the body especially on the chest, head, back, soles of the feet ("*Falanga*") and genital area. Almost all the men in the survey had been severely beaten on the chest until they became unconscious or coughed or

vomited blood. Some men had received violent blows to their ears ("*Telefono*") which had led to hearing loss and chronic infection of the middle ear. Either a single serviceman or a group, were involved in torturing.

After beating it is common for the victim to be hung from a rope which is tied to a beam. He is suspended in an awkward position, sometimes upside down by the feet or toes or by the hands or thumbs which were tied behind his back. The victim hangs about three feet from the floor for some time with the entire weight of his body felt through, for example, his shoulder joints and thumbs, which could lead to painful dislocation and permanent damage of joints. At other times detainees are tied up with their knees tucked under their chins and suspended from piping passed behind their knees. While the detainee is hanging he is repeatedly beaten. It is possible that the dehumanising effect of trussing someone up like a ball or hanging them upside down facilities the torture in turning a person into an enemy 'object'. In this way the torture can distance himself from the reality of his actions and deny the murderous treatment of a fellow human being.

It is common for chilli powder to be rubbed on fresh wounds left by beatings and also onto the genital organs. In some, the force feeding of chillies led to stomach ulcers. Others were forced to breathe burning chilli powder smoke which led to lung damage.

Electrocution using six 1.5V cells or a car battery had been experienced by some. Various parts of the body, such as the chest, ears, tongue, genitals and shrapnel wounds had been touched with the wires. This treatment left small round scars on the skin. Other larger scars were left after the skin was burned with heated iron rods or cigarettes.

Some had damaged nail beds from having pins introduced under the nail or nails had been completely extracted.

Some had been buried in the ground, up to the neck. This caused suffocation due to the restricted movement of chest.

Sexual abuse was reported by some ex-detainees. Male prisoners were made to stand with their genital organs on a table. This part of the body was then hit by a soldier using a short sand filled piece of PVC pipe or wooden strips. Wire loops were sometimes inserted into the male organ ripping the skin, and men were kicked between the legs. Objects were inserted into the anus. The female ex-detainees related that rape or sexual humiliation of women was common place.

In those who were surveyed these physical methods of torture led directly to the observed physical sequalae and problems of residual lesions-fractures, malunion of broken bones,

chronic bone infection, chronic ear infection, impaired hearing, eye problems, chronic headaches, chronic respiratory tract infection, dental problems, sexual problems, haemorrhoids, difficulty in walking, chronic chest pain, generalised body aches, and restricted movement of leg and shoulder joint. Two of the ex-detainees had suspected neurological damage. Almost all of the physical methods of torture were found to ultimately lead to psychological problems.

Common Psychological methods of Torture

In our survey, the following methods of psychological torture were reported. The most damaging experiences involved witnessing the torture or death of a relative or friend. Often detainees were threatened that other family members would be arrested and tortured. The forced watching of others suffering was said to be extremely traumatic and often more so than the actual receiving of physical torture. Cases of one detainee being forced to kill another with the other prisoners watching were described.

All detainees were kept incommunicado in the sense that communication with others outside the detention camp or prison was prevented. They were only allowed to see relatives, lawyers and medical personnel in exceptional circumstances. Some referred to the times they were kept in solitary confinement.

Food was sometimes withheld for several days at a time, and meals were reported as being inadequate in quantity and quality. Prisoners were sometimes deprived of sleep and the constant fear of being the next one to be hauled out of the cell, meant that often sleep was impossible. The small over-crowded cells were sometimes too small to allow everyone to lie down to sleep. Detainees were usually not allowed to go out of the cell to urinate or defecate from 6pm to 6am, but were given bottles and plastic bags for this purpose.

One man described the poor hygiene in the prison in which he was held and recounted that whenever the cess pits became full, detainees were made to clear them using the buckets which were normally used for retaining drinking water. Health problems such as rampant scabies and spread of other infectious diseases were not looked after. This situation of poor medical attention greatly distressed the prisoners and made them feel sub-human.

The psychological forms of torture described in the previous few paragraphs led to weakening of the will or spirit of the detainees and produced feelings of helplessness and exhaustion.

Sometimes they lost the will to live and felt that their personality had been destroyed. Some reported that they felt extreme guilt when they thought they were responsible for someone else's death or torture.

Another way of confusing or psychologically breaking a detainee was to use the friendly and unfriendly interrogator technique. After violent torture carried out by torturers of low rank, the victim was interrogated by an officer of higher rank in an atmosphere of tranquillity and polite conversation. The prisoners found that in these circumstances of deep distress it was difficult for the victim to resist complying with the officer. Being tricked and weakened, in this and other ways, left the prisoners feeling that they had let themselves down and had lost their self respect. Worse still if they felt that they had given information precious to their cause or that would endanger someone else, they felt crippling distress and guilt. A quote from Somnier and Kemp-Genefke relates to the impossible situation that some of the ex-detainees in the area were faced with. They wrote, "his only way out is confession or denunciation which could eventually secure his physical life, but which are a serious threat to his spiritual life."

Some detainees described a feeling of listlessness or passiveness because of their total inability to control the slightest aspect of their lives; even whether they lived or died was entirely up to their captors. This 'learned helplessness' was deepened by the fact that usually the torture given was meaningless to the victim and continued whether or not they co-operated. For example, someone could be taken away for beating for walking slightly slowly or standing a fraction out of line in the food queue, on the other hand people could be chosen for no apparent reason. This inconsistency in punishment made every action of the day an agonising trial. Prisoners felt that they had become totally helpless when they found that even their feelings of aggression towards their captors and their ability to believe in fighting back had lessened with time.

AFTER EFFECTS OF TORTURE

The assumption was made that more extreme physical and psychological problems, noted in the questionnaire and during the interview, were a direct result of the person's experiences while in detention. However, some of the problems found may have existed before imprisonment or may have arisen even if the person had not been tortured. In a retrospective study such as this it would be helpful to study a control group. However, at present with limited resources and in the prevailing difficult circumstances such a study has not proved possible. Later in this chapter the results of the survey are compared

with some results from other studies of torture survivors carried out in Denmark and Canada. The results of the study show the same general trends as these other studies and this is taken as some indication that questionnaires were filled in and interpreted with some validity.

THE PHYSICAL PROBLEMS FOUND IN THE EX-DETAOMEES

Tables A and B show the physical ailments that ex-detainees had while in detention and those they had at the time of interview.

A. The common physical problems which they had when they were in detention:-

		No. of cases	%
1.	Itching (scabies and ringworm)	135	84.38
2.	Chest pain	103	64.37
3.	Headache	88	55.00
4.	Other aches and pain	103	53.75
5.	Fever	52	32.50
6.	Chicken Pox/measles/mumps	32	20.00
7.	Diarrhoea	30	18.75
8.	Abdominal pain	20	22.50
9.	Fainting and giddiness	15	09.38
10.	Swollen painful soles & heels	11	06.88
11.	Coughing with blood	06	03.75
12.	Vomiting blood	04	02.50

Itching, diarrhoea, chickenpox, measles, mumps and fevers were mainly due to poor sanitary and overcrowding conditions. In a 70x20 feet detention cell about 175-225 detainees were commonly held. Prisoners were not given adequate safe drinking water and only a little water was given to clean their bodies. Improving the sanitation of the camp and giving enough space to each detainee would have reduced the above mentioned infectious diseases.

Chest pain, headache, aches and pain, abdominal pain, swollen painful heels, coughing of blood and vomiting of blood are related to the physical methods of torture; 4 of those interviewed had swollen genitals; 2 had urination problems, and 2 had bleeding from the ears. These physical conditions were directly attributable to the physical methods of torture used.

B. The physical problems which the ex-detainees had at the time of interview:-

	No. of Cases	%
Weakness of body	139	86.66
Impaired hearing (Some with remaining chronic ear infection)	55	34.38
Eye problem i.e. -Blurred vision -Night blindness -Tearing of eyes -Unable to see in bright light	89	55.63
Skin disease i.e. -Scabies -Ringworm	89	55.63
Dental problems i.e. -Fracture -Caries	66	41.25
Weight loss	126	78.75
Fracture malunion and chronic bone infection		24.38

5 of the interviewed ex-detainees were found to have haemorrhoids, one victim had hernia, one victim had a bleeding nose, one victim had chronic inflammation of his testis.

Discussion of the causes for the above mentioned physical problem:-

78.75% had weight loss and 69.38% had loss of appetite. Loss of appetite may be the main cause for the loss of weight. Loss of appetite may be attributable to learnt behaviour.

When they were in detention only a small quantity of unpalatable food was given, therefore they become accustomed to not eating much and through this learnt behaviour they may be unable to eat large volumes after leaving prison. Hyperacidity due to anxiety also leads to loss of appetite. Loss of appetite and weight are prominent signs and symptoms of depression which many of the ex-detainees had. Eating problems may be overcome by changing learnt behaviour and reducing anxiety.

55.63% of the ex-detainees had skin diseases such as scabies and ringworm at the time of interview. These categories of parasitic and fungal infection were due to overcrowding and poor sanitation in the detention camps. 55.63% have eye problems such as blurred vision, night blindness, tearing of eyes and an inability to see in bright light. Eye problems may result from prolonged exposure to bright light, while vitamin A deficiency due to poor nutrition can also directly impair vision.

41.25% have ear problems, mainly deafness and chronic ear infection. These conditions are attributable to violent blows to the ears with the palm of the hand (*Telefono*). This leads to rupture of ear drum, then to infection. Rupture of ear drum with chronic ear infection leads to conduction deafness. A blow on the head might lead to nerve deafness. 24.38% were suffering from malunion of fractures end chronic bone infection. Many of these ex-detainees had difficulty in walking.

36.88% had generalised weakness of body. This may be psychosomatic in origin. 55% had chest pain due to violent blows to the chest with clenched fists. As a result of chest pain the victims fail to breath properly and are prevented from taking deep breaths, this in turn further restricts their chest movement. The result is in poor oxygenation of blood which ultimately leads to generalised weakness of body. As breathing exercises and chest physiotherapy may improve this condition, rudimentary advice on these procedures was given wherever possible.

THE PSYCHOLOGICAL PROBLEMS FOUND IN THE EX-DETAINEES

The questions on the form given to the ex-detainees which related to their psychological well-being or problems were designed to survey the general levels of depression, anxiety and trauma found in this group. The percentage of those having common psychological problems are given below, as are some of the general observations made during the interview. The categories of emotional disturbance are listed in order from most common to least common.

	Number	Percentage
General and deep sadness	139	86%
General tiredness	139	86%
General nervousness	135	84%
Recurrent intrusive memories	128	83%
Memory impairment or poor concentration	125	79%
Loss of appetite	110	69%
Intensification of symptoms by symbolic association with trauma	108	68%
Extreme fear	106	66%
Headache, giddiness, fainting	103	65%
Low self esteem	92	59%
Nightmares & sudden awakening	91	56%
Extreme mistrust & suspiciousness	80	50%
Unusual irritability & aggressiveness	74	46%
Sweating during interview	74	40%
Suicidal thoughts	61	38%
Behavioural changes leading to social withdrawal	61	38%
Crying or watering of eyes during interview	48	30%
Sexual dysfunction	40	25%
Suicide attempts	01	0.5%

The large majority of the ex-detainees could be described as showing both anxiety and depressive symptoms which are greatly disruptive to the normal run of their lives. Many (50%) were distrustful to an extent which would normally be considered paranoid and

this tended to affect even their closest relationships as well as making them socially withdrawn (38%).

It is the profound loss of trust in others and the acquired dislike of being touched which led some to have problems with their sexual functioning (25%). Others who had been sexually abused as part of their torture, found that distressing memories interfered with their enjoyment of their partner's attentions. The commonest sexual problems found were impotence, premature ejaculation and loss of interest. One particular man had a fear of infertility directly produced by comments his captors had made while he was under torture.

The interview brought up strong emotions in many of the ex-detainees, 30% of clients became tearful and some openly cried. Many, as they shared their feelings became very tense and began to sweat profusely. Generally, the men seemed preoccupied and were easily distracted. Most men could not relax and sat rigidly on the edge of their chair, picking or knotting their fingers. Their eyes were kept widely open with raised brows which gave them a startled appearance.

The affect of the ex-detainee corresponded well with the accounts they gave of their emotional states. The figures in the table above give a catalogue of the deep psychological damage suffered after torture. It is not surprising that nearly all (86%) felt that a deep sadness had overtaken their lives. General tiredness affected 86%, and poor concentration and loss of memory appeared to be a real problem to 79% of the clients. These debilitating symptoms were seriously affecting the social lives and the working and earning capacity of many.

Low self-esteem was another feature which was mentioned by 59% of the clients. This was often related to their real or felt inability to work like others, their poor sexual performance and to feelings of rejection by the family and by their society. The combination of low self-esteem and extreme anxiety in some led to social withdrawal.

Just under half (45%) of those interviewed felt that their experiences in prison had led them to become significantly more irritable and liable to be rude and flare up in anger. Some mentioned that they became irritable and anxious when they left the security of their homes, and others felt that they were frustrated and irritable with their families and in the confines of their homes. One man said he became angry and shouted at his sisters for the slightest reason, particularly if she gossiped about the neighbours. He himself had become socially withdrawn and had reduced his communication with his neighbours.

Over a third of the torture survivors (38%) had thought of ending their lives since they had left prison. Those who expressed strong guilt feelings were often also suicidal. Some felt guilt about their survival while others they knew had died, and others felt guilt about the financial and family problems arising from their detention and subsequent unemployment. One of the clients felt very guilty that the family money saved for his sister's dowry and wedding was spent on him. The constant fear of re-arrest by the army or by one of the opposing groups led some to consider suicide. One torture survivor had attempted suicide twice. He had been released a month before we saw him after twenty-six months of detention.

Post Traumatic Stress Disorder

These debilitating features greatly surpassed anything normally seen in normal anxiety and depressive disorders and are difficult to classify within the normal tradition of psychiatry. If the various debilitating features found in these ex-detainees are related to the psychiatric category of Post Traumatic Stress Disorder (using the DSM III diagnostic manual) then the total number falling into this category is 137 of the 160, or 85% of the ex-detainees interviewed. The reverse of this statistic is that only 15% of those interviewed appeared to be coping with their lives following their detention and torture.

It was found that even the shortest detention period of one month included in this study was enough to produce a clear PTSD classification. A college student after a thirty-day period of detention complained of constant tiredness, poor concentration and loss of memory. He reported that he was continually preoccupied by memories of his traumatic experience, and frequently woke up shouting after severe nightmares.

Recurrent intrusive memories were experienced by 123 clients. Some felt faint during such recurrent memories. 68% developed tremors and reactions triggered by environmental stimuli. For example, one client who was strung up on an old fashioned ceiling fan and rotated during the torture now avoids going to places, such as restaurants, which have similar fans. If he happened to see a similar fan, he would develop a headache and would break out in sweat and feel giddy and faint. Intensification of symptoms by symbolic association with trauma was described by 68% of clients. A client used to get angry when food was spilled on the floor or table. This event made him remember the starvation he had experienced in the camp. Whilst there, he had used a pin to pick up the spilled food from the floor to eat one crumb at a time. He had then used a pin to wash each crumb with water , as they were mixed with small stones and and sand.

Depression

Biological symptoms of depression were found in 69% of the clients, which indicates that this percentage of the ex-detainees were suffering from moderate to severe depression. Loss of appetite and weight loss are the most prominent biological symptoms of depression found. Loss of sleep may be attributed to anxiety, vivid dreams and recurrent intrusive memories. One form or another of sleep disturbance was found in 67% of those questioned.

Anxiety

Anxiety disorders were commonly found and co-existed with depressive illness in the torture victims. Fear, the basic symptom in anxiety disorder was a complaint of 66% of the clients. They usually had an extreme fear of military personnel and of being re-arrested. As the war situation continued around them these fears were well justified and often re-arrests were made, sometimes as a direct consequence of their fear reaction which made the army suspicious. Physiological fear reactions and panic attacks were often induced by 'neutral' environmental stimuli. By contrast, some of the ex-detainees instead of feeling fear became disinhibited and no longer had any feelings of saving themselves or keeping out of danger. They felt as if nothing mattered any more. Tremors and nervousness are another manifestation of anxiety. Some felt that they were unable to talk with continuity. Fainting attacks were complained of by some victims. Vivid dreams and waking up suddenly were a symptom of anxiety found in 56% of the clients. The dreams often involved their past traumatic experience.

Factors Influencing the Severity of Trauma

There was little obvious difference in the major features of trauma in ex-detainees who had been tortured for differing lengths of time. The form that the torture took and the attitudes and personality of the ex-detainee were more likely to predict the degree of trauma felt. Those who suffered the greatest degree of stress were those who had received systematic torture which included psychological torture rather than the routine brutal physical tortures.

Most ex-detainees said they had been innocent and their unfair treatment played greatly on their minds. This self-proclaimed innocent group seemed to have more psychological problems than the group who had been directly involved in military-type activities, and who had therefore possibly psychologically prepared themselves for imprisonment.

SOCIAL PROBLEMS FOUND IN EX-DETAINEES

(1) Almost all the detainees who were taken to detention camps are still living in the district after release. Only a few had migrated to foreign countries to seek asylum or had moved away. Most of them could not afford to go abroad by seeking asylum.

Rehabilitation of torture victims should be undertaken in a safe environment but these ex-detainees who belong to various armed groups were still living in a district where the rival groups were in deadly conflict, and many of them had been taken and questioned and re-tortured. Most of the ex-detainees we studied were released about 9 months before the interview but some had been released just days before we saw them. The fighting was still ongoing and the climate was very politically unstable. Villages were regularly surrounded and combed for suspects. Suspected individuals who had been previously arrested by the army were now arrested by others. Some of our clients had been taken for such interrogations.

Necessary political steps should be taken to stop inter-group killings and torture. Unfortunately, these torture victims are still living in the midst of the environment which created their psychological problems. However, even though the inter-groups rivalry is high in the local district the ex-detainees who belong to these various groups appear to be living and working together cordially and in a friendly manner through their "Ex-Detainees Rehabilitation Organisation". At the time of interview all of them expressed their concern and condemned inter-group rivalry.

(2) Unemployment is the biggest problem they have now. Most of them had been doing farming before their arrest but after undergoing so much torture they easily become tired (87%), and have debilitating chest pain (55%). For this reason, many could neither continue their farming and manual work nor any other strenuous work. Because many (52%) have low self-esteem they may not be able to succeed in securing jobs, even where such became available to them. Therefore before giving them employment, they have to be given adequate psychotherapy to improve their self-esteem. Because they cannot do strenuous work, employment such as poultry farming or small cottage industries which need less physical effort would be suitable aid schemes for them. Care should be taken when suggesting employment for them as their families may have preferences.

(3)Changes in emotions, behaviour, relationships with others and socialisation were affected. Anger (73.75%), irritability (61.88%), social withdrawal (38.13%), suspicion (52.80%) and rudeness (46.25%) were all found. Because of these psychological problems they could not form good relationships with their family members and friends. Family members and friends should be educated to understand and respect the ex-detainee's changed behaviours.

(4) 25% of the ex-detainees (the majority being married persons), are suffering from sexual problems such as premature ejaculation, impotence and reduced libido. This type of problem may lead to marital disharmony and ultimately end up in divorce. Therefore the spouses of such torture victims should be given counselling and marital therapy.

(5) 38.75% of them tended to have suicidal thoughts and one had attempted suicide twice. They have to be given adequate psychotherapy.

Some of our observations are as follows :-

1. **Employment :-**Those who got permanent jobs which do not involve much physical labour were coping best. Teachers, Clerks and Priests are examples of this category. Unfortunately, the majority of the victims we saw were farmers who needed significant physical strength to do their job. Most tried to carry out their previous jobs and found them hard to continue with, either emotionally or physically.

2. Financial support :-Financially supported victims recovered from their emotional problems relatively quickly. The victims who had found new suitable jobs reported that this had generally given new meaning to their lives.

3. **Changes involving philosophical approach to life :-**Some rationalise their suffering to their previous involvement in politics. Those who saw, after returning from detention, that the group they worked for previously were still upholding their political goals fared relatively well. They were less likely to cope if they found that the groups for which they worked had given up and deviated from their original goals. Some became very saddened when they saw the violent and anti social methods that their group now employed.

Discussion

The sample for this study was taken from clients who presented themselves for medical treatment and had been in detention for more than a month. We might have missed several affected and successfully coping victims. The presence of the Indian Army during our survey -rather than that of their Sri Lankan captors-facilitated the attendance of the ex-detainee. There was an expectation of financial aid which may have made some clients exaggerate their symptoms.

The questionnaire was written with the help of lay people so that it could be understood by the ex-detainees without altering the meaning of the medical and psychological

terms. Terms over which doubts could potentially arise such as 'mistrust' and 'suspiciousness' were explained by the interviewer.

We found that a trusting relationship between the medical/counselling group and the clients was relatively easily built up, by contrast to studies conducted in refugee centres in Europe. This is probably because the interviewer was of the same background and ethnicity as the client and the client was in his or her home town and surrounded by those who understood the details of the political and social environment in which the arrest and detention took place. Confidentiality was assured by the President of the ex-detainees self-support group. The fact that the team consisted of medical students, with symbols of medical care such as stethoscopes, and included a nun in her habit, helped the clients to open up confidently.

COMPARISON OF THIS STUDY WITH OTHER PUBLISHED WORK

The results of the study on torture victims done by medical/counselling teams are compared with a British Journal of Psychiatry report by R. E. Somnier and I. Kemf Genefka (1986). The main differences between the background conditions of our study and studies done in refugee centres are:

1. In our study the language and cultural background of the medical/counsellor and the client are the same.
2. The interview took place in the ex-detainee's country, and in the majority of cases in the ex-detainee's home town.
3. The time period between torture and the interview was relatively short in our study.
4. The ex-detainees interviewed were still in very insecure war conditions, and re-arrest was a very real possibility.

Complaints	Somnier & Genefka % (n=24)	Our study % (n=160)
Sleep disturbance	83	63
Headache	79	95
Impaired memory	79	86
Loss of concentration	75	76
Fatigue	75	86
Nightmares	71	57
Fear/Anxiety	50	66
Social withdrawal	38	38
Impaired hearing	38	34
Vertigo	33	--
Sexual disturbance	21	25

Another study carried out in Canada on 41 refugees who had been tortured was compared with our study. The results follow:-

	Canadian study % (n=41)	Our study % (n=160)
1. Psychosomatic problems		96
Pain headache	53	95
Nervousness	80	84
Insomnia	68	68
Nightmares, panic at night	34	58
Tremor, weakness, fainting, sweating	63	77
2. Behavioural and personality problems	48	61
Withdrawal, irritability, aggressive impulses	31	38
Suicide attempt	9	0.8
Suicide thoughts	--	38
Sexual dysfunction	12	25

3. Affective problems	95	85
Depression (crying)	70	69
Fear	29	66
Anxiety	87	85
4. Mental function		
Confusion	98	61
Memory disturbance	40	25

Ex-detainees in our study and the Denmark and Canadian studies seem to suffer similar sequalae to torture and the numbers suffering from particular sequalae are fairly similar, although there is a tendency for the values in our study to be higher.

The following features of study are significantly different from the Denmark and Canadian studies:-

Many more ex-detainees suffered from headaches and general body pain, while fewer complained of confusion and memory disturbances.

CONCLUSIONS

The psychological disorders found in the ex-detainees prove undoubtedly that systematic torturing is being carried out in Sri Lankan prisons on political prisoners. Presenting psychological symptoms and their severity were consistent with both the reports of the ex-detainees themselves and with the reports on torture methods in the publications of Amnesty International.

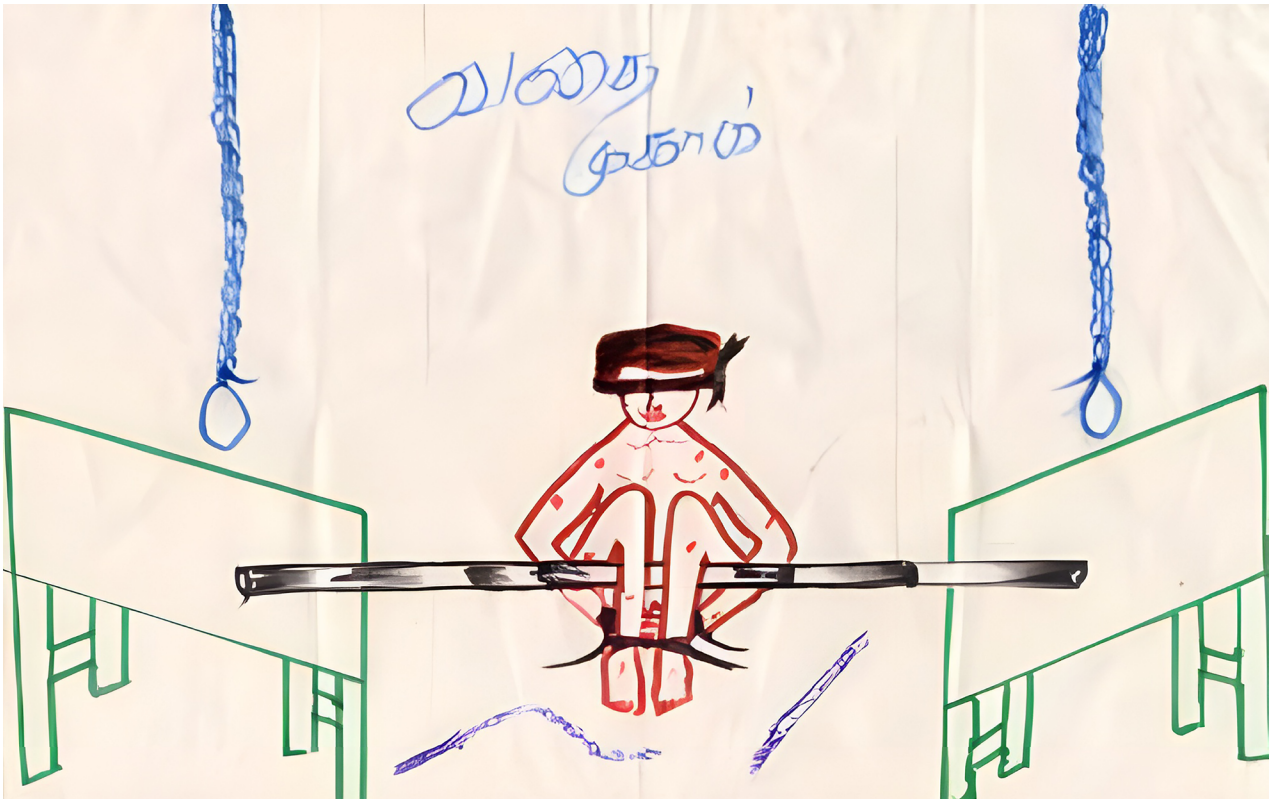
Out of all the psychological sequelae found, emotional problems were the most prominent problem in torture victims interviewed. Emotional problems can be successfully dealt with by counselling and psychotherapy, using empathic understanding and catharsis. These methods of counselling should be used in the first few sessions with any client. Other specific methods can be used later to treat other behavioural problems and cognitive impairments. Active listening alone may reduce emotional problems, but also may have some effect on behavioural problems and impairments. All the clients (about 15) who were seen twice in an interval of 17 days seemed to have started the path of recovery from social withdrawal.

Though most clients looked normal at a first glance, they were found to be depressed and when the period of detention was talked about, they became anxious. Victims of torture frequently show both anxiety and depressive symptoms, a mistrust bordering on the paranoid forms. They suffer from great insecurity and show a loss of interest in their surroundings. These debilitating features greatly surpass anything observed in anxiety disorders or straight forward reactive depression.

There is no definite plan by any authority to help these ex-detainees. As our results show there is a profound fear for their safety among 66% of the clients, and suicidal thoughts are found in 38% of the clients. We believe that the present violent political situation and the poor economic status of the ex-detainees play a major role in preventing their recovery.

REFERENCES

1. Allodi, F. (1980). *The Psychiatric Effects of Political Persecution and Torture in Children and Families of Victims*. Canada's Mental Health, 28:8-10.
2. Amnesty International (1985). *Sri Lanka: File on Torture.* AI Newsletter, October, 1985, London.
3. Amnesty International (1996a). *Prescription for Change: Health professionals and the exposure of human rights violations.* ACT 75/01/96, London.
4. Amnesty International (1996b). *Sri Lanka: Wavering commitment to human rights.* ASA 37/08/96, London.
5. Bamber, H. (1988). Medical Foundation, London.
6. Somnier, F.E. & Genefke, I.K. (1986). *Psychotherapy for Victims of torture. British Journal of Psychiatry, 149: 323-329.*



A curious method of torture used locally is called '*Dharmachakra*' or the '*Parrot perch*' or '*jujuyekebab*' (fried chicken) in Iran, where the victim's wrists are tied together and then suspended in a bent position so that a pole can be passed simultaneously through the crook of the bent knees in front of the elbows (see fig. which is a drawing by a victim). When rotated rapidly like a wheel, there is intense pain to the body but the only evidence will be healing abrasions at the wrist (Fernando, 2001). There is often mental confusion that reduces the mental resistance of the person, making it more likely that they will cave in. The paradoxical use of the Buddhist spiritual term *Dharmachakra* for this type of torture is psychologically revealing (Gunasekara, 2001).[1]

[1] Somasundaram, D. (2010) Torture in Sri Lanka-A method of physical, psychological and socio-political terror under PTA. In Bastiampillai, B., Edrisinha, R. & Kandasamy, N. (eds.) Prevention of Terrorism Act (PTA): A Critical Analysis. Centre for Human Rights and Development (CHRD), Colombo, pp. 73-116.

CHAPTER 8

MANAGEMENT

"Health is a state of complete physical, mental, social (and spiritual) well-being, and not merely an absence of disease or infirmity".

-Preamble to the Constitution of the World Health Organisation (WHO), 1948

INTRODUCTION

Change Our Catastrophic Fate

Bitterness and despair, painful thoughts,
A weary heart, hardened with sorrow,
A heavy weight upon a tensed head,
Mind contemplates suicide.
Who truly understands this war trauma?
Words of comfort from others feel hollow,
Yet, within, the turmoil does not ease.
Suffering takes its place deep in the soul,
And like walking corpses, searching for refuge,
Broken we lay in our room.

-Navaraj
(Translated by Subeasharan Kulasegaram)

A. Treatment

One should not end on the pessimistic note portrayed by the clinical cases, without suggesting some remedy and hope for the future. When considering the treatment of traumatised victims in the North and East, it is helpful to do so under the headings of their physical, mental, social and spiritual needs. These categories are arbitrary and their differing methods of therapy overlap and are interdependent. Thus, the overall approach has to be an integrated one, addressing these various dimensions of needs. Attending to their immediate biological needs, prevents later psychological malfunction by the recognition and care the physical treatment entails, while social rehabilitation goes a long way towards re-establishing the individual's self-esteem and psychological well-being. Coming to terms with traumatic

experience and finding meaning in the suffering provides the spiritual strength to cope and meet any new stress.

During war time, the immediate physical needs of the civilians such as treatment for injuries, shelter, food, clothing and security always take priority. First-aid measures to treat injuries, fractures and haemorrhage until transport to the nearest hospital is available have proved invaluable and saved many lives during the war in North and East of Sri Lanka. Well trained personnel such as primary health workers (Family Health Workers), St. John's Ambulance Brigade and health volunteers now exist within the community to respond quickly to such emergencies. Surgical treatment of the never ending stream of war casualties have taken up most of the time and effort in the functioning hospitals. The basic infra-structure of the health services in the areas has barely survived the onslaughts of the war. Apart from direct attacks on the hospitals and its staff, leaving the hospitals and equipment damaged or destroyed and the staff, dead or injured, there has been a chronic shortage of basic dressings, drugs and personnel (Natchinarkinian, 1994). The general brain drain has hit the health services the most. It is a sad commentary on the Tamil community that there are more of its doctors abroad, for example, in the UK alone, than it has left behind in the North and East. A core of dedicated health personnel have continued to sacrifice themselves in trying circumstances. It has been left to foreigners like the French Médecins Sans Frontières (MSF) and briefly, the Indian Red Cross, to fill in the gaps. Aid agencies and NGO's provided much needed drugs, equipment and other necessities, tragically some of our well to do expatriates have assuaged their guilty conscience by generous contributions towards buying arms. It is reassuring to see some of the doctors abroad organizing themselves, like the Medical Institute of Tamils in the UK, to develop programmes to constructively help their homeland. Happily, many such organizations of expatriates have been doing yeoman service for their home community in its hour of need. At the same time, allocation of resources to the North and East by the State has been glaringly discriminatory (Natchinarkinian, 1994).

In addition to the immediate surgical treatment of wounds, removal of shell fragments, fractures and amputations, long-term rehabilitation efforts have to be organized, which provide artificial limbs to those who have lost them due to land-mines and other war injuries. Prevention and treatment of infectious diseases and epidemics are another aspect that needs resources. Skin conditions like scabies and gastrointestinal diseases due to poor sanitation in refugee camps were wide-spread problems. Epidemics like cholera, which broke out after the Indian invasion, and the persistent threats of malaria

and encephalitis due to cessation of spraying against mosquitoes, along with outbreaks of polio and rabies due to a lack of immunization vaccines, must be addressed. Reports of widespread malnutrition due to war conditions, particularly among the children with implications of permanent brain damage in infants, have been specially worrying (Sivarajah, 1993). Nutrition programmes like the Triposha and other supplements had been non-existent in war affected areas but recently nutritional centres were started in the North under LTTE rule.

Mental Health

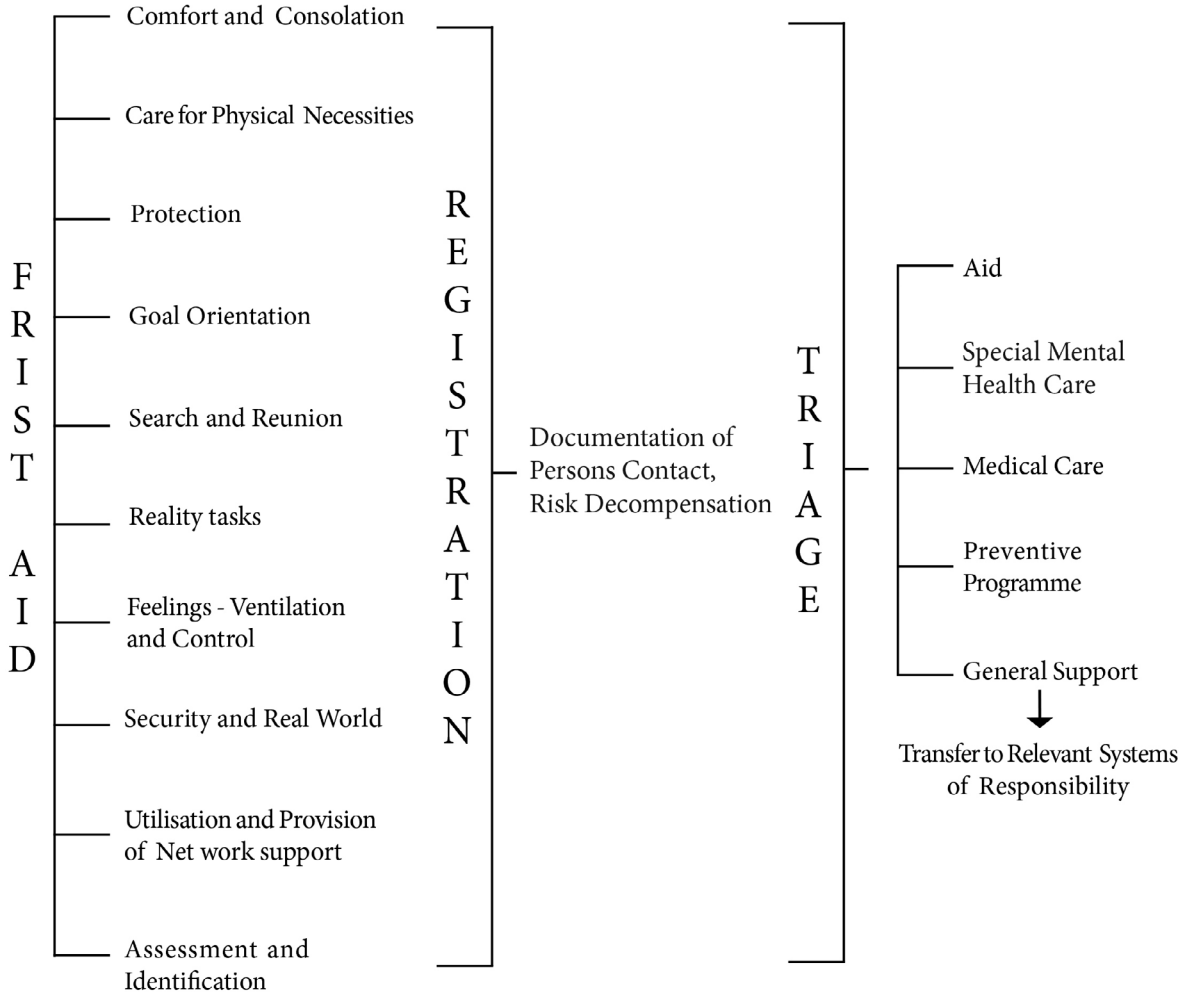
There is considerable resistance when we come to addressing the psychological needs of those affected by the trauma of a chronic war situation. *'Many view mental health services as a non-priority, a luxury, or even a nuisance'* (Raphael, 1986). They see such services as getting in the way of 'real work'. In the case of combatants, the Sri Lankan authorities have continued to deny such a problem exists, perhaps they fear that acknowledgement of mental reactions to war will have a detrimental effect on their motivation to fight, not to mention the cost of compensation claims. However, the LTTE, perhaps more realistically and out of sheer practical necessity, have recognised the need for psychological help for their combatants as well as civilians. Nevertheless, psychological care will carry considerable social stigma and implications of mental disorder (i.e. 'madness'). The first step may be educative, to create an awareness and recognition of the variety of 'normal' psychological responses to trauma as well as possible maladaptive reactions.

"Educational material should explain common post-traumatic reactions, process of grief, family strain in temporary dwellings, the importance of support systems to healing emotional wounds, and many other matters." (Raphael, 1986)

An informative pamphlet, '*Coping with Stress',* produced by the Royal Children's Hospital and Prince Henry Hospital following the Ash Wednesday fires, in Australia, and later effectively used in other post-disaster programmes world-wide was translated into Tamil and distributed locally. It should not be imputed that an individual is having mental problems, but rather that these are normal and natural reactions to extraordinary experiences common in war time.

As has been discussed in Chapter 4, following a major traumatic event such as a bombing raid, at least 25% of the population may be stunned, dazed, apathetic and wandering. Other symptoms of an Acute Stress Reaction include overwhelming distress or disoriented behaviour. Similar responses but of a lesser degree can be expected after most of the acute

war stresses. At this point, psychological first aid will provide basic support and care, while preventing future psychological problems from developing. Professor Raphael (1986) has divided ***psychological first-aid*** into a number of components (see Figure 1).



Psychological first-aid and Triage

Training

It may be necessary to educate and train volunteers, primary health staff, NGO's and community workers involved, on the psychological aspects of relief operations. Topics would include the principles of psychological first aid; the nature of adaptive and nonadaptive responses; the importance of maintaining contact and flow of information to reduce anxiety; advisability of keeping family units together and preventing separation; need for victims to have a role in their own recovery, to make decisions and develop a sense of mastery and control; the importance for the bereaved to see the bodies of those they have lost; and counselling and crisis intervention. Such programmes were run by Shantiam and the Extra Mural Studies Unit of the Jaffna University.

In addition to psychological first aid, many traumatised individuals will need basic support and counselling. These can be carried out at special counselling centres. The Association for Health and Counselling (Shantiam) was set up in Jaffna, with outreach centres in the peninsula, but other centres in each district of the North and East is urgently needed. Some work in Vavuniya, Trincomalee and Batticaloa is being done by the Family Rehabilitation Centre (FRC) from Colombo.

Considering the enormity of the problem, the population that has to be reached and the increasing demands due to the continuing war situation, a community based approach will enable one to reach a larger target population and undertake preventive and promotional public mental health activities as well community level workers should poses skills in counselling and other forms of psychological help. Community care givers such as the primary health doctor (GP, DMO, MOH, etc.). Family Health Workers (FHW), teachers, ministers, traditional healers, priests, monks, village elders, gama sevakas, etc. may need to have brief training in counselling methods. It may be more judicious to introduce the training as a part of their regular curriculum, for example of potential grass root workers like medical students, FHW's, nurses, teachers and ministers. Training for community workers is being done by Shantiam, FRC and UNICEF, but needs to be expanded. UNICEF has been using the training manual, *Helping Children in Situations of Armed Conflict (*Nikapota & Smarasinghe, 1996) to train FHW's and community workers. Educative booklets, *Manavadu* (Somasundaram, 1993) and *Ula Vallathurai (*Damian,1994) have been prepared in Tamil by the Department of Psychiatry at the University of Jaffna to serve as basic texts, and all health staff undergo training in handling trauma as part of their curriculum in the North. Some useful community based approaches to be discussed below are given in Box 1.

Box 1 Community Approaches

- General Awareness
- Training of community workers
- Public mental health promotive activities
- Encourage indigenous coping strategies
- Cultural rituals and ceremonies
- Community interventions
    1. Family
    2. Groups
    3. Expressive methods
    4. Rehabilitation
- Prevention

Counselling

Counselling is basically aimed at giving support through an empathetic and trusting relationship. It should be non-directive or client-oriented in that the client should be allowed to work out his own solution and come to his own decisions, the therapist merely reflecting what is being thought and said, Patient, non-judgmental listening becomes the crucial technique, while warmth and support the appropriate response.

A few principles of counselling that have been used in counselling trauma survivors in the North are as follows:

1. Support, reassurance, education.
2. Information that such reactions are common, natural and have been experienced before by others. The leaflet '*Coping with Stress*' can be given.
3. Warmth, Empathy, Sympathy, Communicating your concern.
4. Opportunity to tell their story. "Listening"
5. Catharsis/Abreaction. Let the clients express or ventilate their emotions.
6. Problem solving-Crisis intervention. Reinforce adaptive coping strategies.
7. Restructuring, reorienting life activities. Necessary referrals to aid agencies, NGO's and community organisations.
8. Insight-Making appropriate attempts to establish a link between the stress and the physical and psychological symptoms.
9. Meaning-Help define and construct a meaning for what has happened. Find a purpose.

The aim of counselling should be to provide a conducive environment which allows the victim to talk through their experiences and feelings, and regain a sense of purpose. It is important to reinforce individual adaptive strategies and supportive interactions with family and community, to sharing of feelings, perceptions and interpretations of the experience. A vital role of counselling services may be to integrate and co-ordinate the various social services; referral to appropriate aid organisations; give information and help the individual contact emergent community groups; and attend to basic physical and medical needs. Some brief psychotherapeutic techniques can be usefully integrated into the counselling services:

Crisis intervention is aimed at focusing on the most pressing problem at hand and evolving strategies to deal with it within the context and resources available. Caplan (1961) developed crisis-oriented brief therapy by viewing crisis as a period of special fluidity, one in which psychic change might even be easier or faster than during times of stability and where maladaptive response can be corrected before it becomes fixed.

Testimony method of treatment uses the need for documenting details of the traumatic event for statistical and administrative purposes as a therapeutic tool by promoting the review process of working through and expression of emotion (Raphael, 1986).

The reader will readily appreciate that this present effort of writing down the experience of war itself is the testimony of the author, and may be personally cathartic by releasing the bitterness, frustration, the anguish and the tragedy of it all. It is in the final analysis, a testimony to a people and land ravaged by war.

Psychotherapy

Some form of psychotherapy remains the treatment of choice for most cases of traumatization. For ultimately, traumatization shatters the cognitive self-schemas and world view of the victim. These will have to be painfully reconstructed if recovery or healing is to take place. Various degrees of psychotherapeutic techniques ranging from listening, through counselling to brief dynamic psychotherapy can be effective. The basic principles include building a trusting relationship, listening to the story, helping to ventilate emotions and come to terms with what happened. The aim is to aid the working through process so that the traumatic event can be integrated into the self system.

For many traumatised individuals, basic counselling and encouragement to use their own coping skills, plus the support of the family and community will be adequate. But for those exposed to severe or chronic stresses of war, or those predisposed by their neurotic personality or special vulnerability (certain groups are at increased risk: multiple deaths, overwhelming destruction, children separated from parents, rape & torture victims) may develop more serious post-traumatic stress reactions like PTSD, Anxiety and Depression. These individuals will need specialised care and probably, more prolonged therapy. It is essential that individuals developing post-traumatic

complications be recognized early and referred to appropriately skilled mental health professionals, if one is to prevent the disorder from becoming entrenched and more difficult to treat.

For PTSD, brief dynamic psychotherapy is the treatment of choice. According to Horowitz (1986), the therapeutic approach has to be oriented to the phase of response(denial or intrusion, see Chapter 4), the character of the patient (coping defensive styles) and the immediate situation. Traditionally, for example, during World War II, abreaction and catharsis using hypnosis and narcosis was the common treatment for post-traumatic disorders. Abreaction, usually carried out under hypnosis or the 'truth serum' (pentothal) which reduced resistance and defenses, entailed the patient recalling the traumatic event in florid detail. This communication itself was therapeutic. In catharsis, the pent-up emotions are released. These forms of treatment are appropriate for the denial-numbing phase where the individual is using strong controls and defenses to deny their emotionally distressing experiences. Thus, therapy should be directed at reducing controls (i.e. by abreactive-cathartic methods) so that there is emotional release and the working through process restarted. Support may be needed while the event is reviewed, interpreted and assimilated.

During the Korean, Vietnam and Arab-Israeli wars, a brief period of, rest and sedation - (the (in)famous R&R) - was considered the best treatment (and prevention) for most war stress disorders. These forms of suppressive treatments are best for the intrusive phase, where due to weak controls, the client is overwhelmed by distressing emotions. There is an increased risk during this phase of becoming dependent or addicted to alcohol or drugs in an attempt to reduce the intrusions of painful memory and emotions. The aim of treatment during the intrusive phase is to encourage controls and give support so that the client can gradually face up to the traumatic event.

Using these various techniques, Horowitz (1986) has evolved the phase-oriented treatment (table 1) for stress response syndromes. The therapy can be complicated as different aspects of the trauma can be at different levels of processing. In cases of multiple or chronic trauma the therapy becomes much more difficult.

Table 1 Phase Oriented Treatment for Stress Response Syndromes
(From Horowitz, 1986)

Denial-Numbing Phase	Intrusive Phase
Reduce controls - Interpret defenses and attitudes that make controls necessary. - Suggest recollection	**Supply structure externally** - Structure time and events for patient when essential - organise information **Reduce external demands and stimulus levels** Rest provide identification models, group membership, good leadership, orienting values permit temporary idealisation, dependency
Encourage **abreaction** Encourage **description** - Association - Speech - Use of images rather than just words in recollection and fantasy conceptual enactments. - Possibly also role playing and art therapy **Reconstructions** to prime memory and associations.	**Work through** and reorganise by clarifying and educative interpretative work Differentiate: - Reality from fantasy - Past from current schemata - Self-attributes from object attributes Remove environmental reminders and triggers, interpret their meaning and effect **Teach "dosing"**, e.g. attention away from stress-related information
Encourage **catharsis** Explore emotional aspects of relationships and experiences of self during event Supply support and encourage emotional relationships to counteract numbness	**Support** Evoke other emotions, benevolent environment, selective use of antianxiety agents **Desensitisation** procedures and **Relaxation**

Further, not all clients will benefit from psychotherapy. The 'talking cure' will be new to the culture and many may resist verbal communication or 'psychologizing'. Using supportive techniques and symptomatic relief within the psychotherapy as described by Van de Veer (1993) can be effective. More specific mental disorders like Anxiety, Depression and Reactive Psychosis will need treatment in their own right. Beyond all these standard treatments, victims exposed to organized violence like torture may need more long-term, perhaps residential treatment. Women who have been raped and otherwise violated, and children exposed to massive trauma are other categories of persons needing long-term, individualised treatment.

Severe Trauma

Torture is aimed at destroying the personality of the individual and therapy has to slowly reverse the process by re-establishing the survivors' self-esteem, trust in themselves and the world. Experience gained at various centres around the world for treating torture victims such as Copenhagen, London and Toronto have shown that an integrated, multi-disciplinary and caring approach can help a large number of those whose lives and personalities have been shattered by their experience of torture and other forms of organized violence.

In studying the various methods, models, and treatment plans adopted at these centres, several basic principles of treating torture as well as all types of severe trauma emerge, which will now be briefly summarised and discussed, with our experiences in setting up similar centres in the North and East of Sri Lanka.

1. **Initial screening and referral:** Many may need basic medical care like treatment of scabies, anaemia, infected wounds etc. In addition, a good number will require specialised care and should be referred to the appropriate clinic or consultant in the local General Hospital. These may include Orthopaedics, Ophthalmology, Dermatology, Neurology, Surgery etc. Care must be taken to avoid unnecessary medical procedures as these may trigger re-experiences of the trauma (see PTSD in Chap. 4). Even going to hospital, facing an authority figure like doctors, or undergoing X-rays, ECG's and blood tests may remind victims of their torture and can be extremely trying for traumatized individuals. Women may need gynaecological opinion which must be handled with circumspection. A team of volunteers or social workers may be needed to accompany the referrals to NGO's, government and social agencies for the purpose of recording, documentation, legal and financial help and rehabilitation aid. Again, the services of volunteers or social workers will be essential to help the individuals with the bureaucracy, queues, questioning, and filling forms which

they won't be in a fit state of mind to face. The screening and referral functions can to a large extent be undertaken by a centre for counselling but it may need to be expanded and further centres established in each district. A questionnaire and interview schedule, the Stress Impact Questionnaire (SIQ) given in annexure 2, to detect and treat traumatic stress disorders due to the war has been prepared and used for this purpose in the North (Somasundaram & Sivayokan,1994).

2. **Psychotherapy:** From the initial contact an atmosphere of mutual trust and therapeutic alliance must be established. Basic counselling may be sufficient and appropriate in a large number of cases. An opportunity to "*tell their story*" in a non-threatening and accepting atmosphere, express their repressed emotions, and receive the support and the warmth of the therapist may be all that is needed. Brief psychotherapy, testimony method of therapy, bereavement counselling, crisis intervention, problem solving, relaxation techniques and other short term therapies could be carried out where necessary. Again, the Association for Health and Counselling is carrying out such therapeutic work. Similar centres will be needed in other districts. The staff for these centres could be trained at Shantiam.

Studies of victims of organized violence including torture show considerable emotional and social handicap. These more severe symptoms may need longer therapy, sometimes extending to over 6 months. The individual's destroyed personality and identity, mistrust of the world, emotional and social withdrawal, and interpersonal problems may have to be gradually addressed in a systematic way. Thus, long term psychotherapy adjusted to the individual's need and pace of recovery may have to be undertaken. Psychotherapy to build a trusting and sustained relationship within which the client could work through his or her experiences, become aware of the various maladaptive defense mechanisms, make meaning of his or her present situation and look hopefully towards the future may be necessary.

Spiritual beliefs and strengths have been found to make people more resilient. Thus, a much more ambitious aim, termed logotherapy (Frankl, 1959) is to find meaning in what happened. For once meaning is found most clients appear to recover quickly. Again, the cultural and religious beliefs, for example the doctrines concerning Karma and suffering, central both to Buddhist and Hindu systems, will be important. Attempts should be made to co-opt sympathetic traditional resources such as priests, monks and healers as co-therapists or in the traditional nosology, as allies, in the therapeutic endeavour. It is not without significance that emotive religious practices, such as *Bhakti*, and charismatic movements have become popular in war affected areas of Sri Lanka.

Group therapy has been found useful, specially in the Philippines which is similar to our setting. The formation of ex-detainee groups, self-help groups, women groups, mother groups and other groupings of affected individuals have happened out of need in some cases (see Chapter 7) and should be encouraged wherever possible. A therapist can then facilitate the interactions within these groups, which in time should develop its own healing and caring processes. Experiences of one individual could be very useful to another and more acceptable coming from another like him or her. In addition, the services of those who have already recovered may prove invaluable in helping others and running the programme. Individual who have survived severe stress like torture would have already developed coping strategies that could be used in the therapy of others.

-War widows group

Family therapy is an important therapeutic tool. In our culture where the family bonds are very strong, the family is an essential resource that can be used in therapy. A traumatised person will usually have disturbed relationships within the family, marital disharmony due to manifestations of post-traumatic symptoms like irritability, withdrawal, depression, sexual difficulties, repressed rage and suspicion. Traumatised children and women could also be treated within a family context. The principles of family dynamics are used to facilitate supportive and healing relationships while counteracting damaging and maladaptive interactions. Communication of individual problems leading to an awareness of each other, one's role and encouragement towards mutually interdependent functioning is used to build up family unity.

3. Cognitive-Behavioural methods: Cognitive-behavioural therapy is very effective in the treatment of PTSD, specially in chronic PTSD and for those not suitable for the 'talking therapy', counselling or psychotherapy. Essentially this amounts to systematic trauma desensitization by exposure, by having the client confront the traumatic event After teaching the client relaxation methods, a hierarchy of the details of the traumatic event(s) from that causing the most distress to lesser arousal is established. Then one works up the hierarchy, having the client call up the incident in visual imagery or otherwise while in a relaxed state. This form of exposure is done until the client is able to confront the particular event without distress. Then the next incident/event in the hierarchy is taken up for desensitization. Several sessions, will be needed for one course of treatment. Eventually, due to information processing and habituation, the client is able to recall the traumatic event without any distress or confront situations and stimuli that they have been avoiding. Considerable cognitive restructuring of the traumatic

memory takes place to make it less threatening. New forms of cognitive-behavioural therapy for trauma based on the similar principles such as Eye Movement Desensitization and Reprocessing (EMDR), Thought Field Therapy (TFT) and Emotional Freedom Therapy (EFT) have become popular in the West.

4. Relaxation Techniques: Based on Jaccobson's Progressive Muscular Relaxation, culturally acceptable methods of Yoga or Buddhist practices can be quite effective for several of the consequences of traumatization, namely states of arousal, anxiety and somatization. Much of the somatic pain experienced by trauma survivors, especially torture victims, is caused by prolonged muscle tension. Relaxation will counteract this. Similarly hyperventilation is a common problem and the basis for many of the psychosomatic complaints (see Chapter 4). Slow, deep, relaxed breathing can be taught to rectify this tendency. Four basic methods adapted to the culture and religion of the client have been developed (see annexure 1) by us:

Breathing Exercises - Breathing, usually an unconscious or involuntary process, has been found to be closely linked to the emotional state, tending to become shallow, rapid and irregular when disturbed, progressing to hyperventilation in extreme reactions. The goal in therapy, is to bring breathing under conscious control and make it deep, smooth and regular. This usually entails learning abdominal, diaphragmatic breathing in contrast to the usual thoracic type of breathing. In Hindu settings, the yogic method of *Pranayama* and for Buddhist clients, Mindful breathing or *Ana Pana Sati* can be taught. A mantra or word (*OM)* can be said such as *O* while breathing in and *M* while breathing out. For others, regular abdominal breathing is explained.

Progressive Muscular Relaxation - For most clients, Jaccobson's technique can be taught. Hindu clients can be taught the technically similar Yogic exercise, *Shanti* or *Sava Asana.* Buddhists can practice *Mindful body awareness.* Other physical exercises, specially *Yoga* and *Tai-chi,* are well known ways to produce relaxation and a sense of physical and mental well-being.

Repetition of Words - In this method of *Japa*, a meaningful word, phrase or verse is repeated over and over to oneself. First, this is done vocally, then after some weeks of practice, as a whisper, then subvocally and then finally, just the thought. For Hindus the Mantra given to them during initiation by their Guru or the *Pranava mantra, 'OM',* can be selected. For Buddhists it could be *Buddhang Saranang Gachchami,* in Islam it can be *Subhanallah* and for Catholic Christians, Rosaries or the Jesus prayer (*Jesus Christ have mercy on me*) or prayer beads. For Muslims, this could include dzikir, takbir, or

tasbih (e.g., Subhanallah). Secular approaches such as Transcendental Meditation (TM) or Benson's relaxation response use a similar repetitive-phrase technique.

Meditation - Various meditation practices are in use. For Buddhists *Vipassana meditation* and for Christians, *Contemplation,* can be chosen. The only contraindication being schizophrenia or other psychotic illness. (See Appendix I Relaxation techniques for detailed explanation)

Physiotherapy has been found useful in treating victims of torture, particularly the common complaints of musculo-skeletal pains. Various forms of massage are used by the different centres. In addition to directly focusing on painful areas like the sole of the feet, head, neck, back, joints and other areas that may have been injured, leaving scar tissue, the massaging induces a state of relaxation, warmth and trust that is useful in therapy. Physiotherapists have commented on using touch as a means of communication. Massage using traditional methods like *Ayurvedic* or *Siddha* oil massage are both culturally familiar and effective. It is good practice to involve traditional practitioners and others in therapeutic programmes, for, in addition to mobilising available resources, it will help to spread awareness and knowledge about trauma in the community. Further, it can tap into hidden talents and skills. For example, the traditional practitioner giving oil massage in our unit was found to be very good at communicating with her clients, many, particularly young combatants recovered from their problems by just talking to her.

In torture survivors with musculoskeletal pains and distorted body image due to the systematic infliction of excruciating pain and injury to various parts of the body, relaxation methods, massage and yoga have been found to be useful.

Calling these cultural techniques as relaxation exercises may be a misnomer leading to an underestimation of their value. When methods are culturally familiar, they tap into past childhood, community and religious roots and thus release a rich source of associations that can be helpful in therapy and the healing process. Further, mindfulness and meditation draw upon hidden resources within the individual and open into dimensions that can create spiritual healing and give meaning to what has happened. Although these techniques are not formal psychotherapy, they may achieve similar goals by activating cultural and spiritual processes.

Considerable effort was put into the training of personnel in the aforementioned Yoga techniques, teaching it to the public, and specifically in the treatment of traumatized individuals, and particularly torture victims. The services of local experts and training of our personnel at the Vivekananda Kendra Yoga Research Centre in Bangalore through

Dr. Ponna Wigneraja's MADAM trust was pursued towards this end. It was felt that with sufficient trained personnel and motivation, Yoga could be introduced into the regular school curricula and thereby benefit a large number of students. When Yoga is practised regularly in the correct way, it helps the child to express pent-up energy and emotions in a healthy way and thus is a promotive, preventive and curative method of health that can be used at a community level.

5. Pharmacotherapy: When there is coexisting Depression as there invariably is in more severe post traumatic states requiring drug treatment, the response to anti-depressants is good. In PTSD too, there is positive improvement with anti-depressants, particularly in the intrusive phenomena and nightmares. Low doses of Imipramine (25mg) works in the majority of cases. The dose can be increased gradually depending on the response on one hand and side-effects on the other. With larger doses (>50mg), side-effects start appearing. Some may not be able to tolerate even the low dose. An alternative is Amitriptyline, which is particularly useful for associated sleep disorders. If there is heart disease or other contraindications, less cardiotoxic anti-depressants will have to chosen. Treatment will have to be continued till improvement is stabilized by psychotherapy or by the patient themselves. Usually the duration of therapy lasts for a few weeks or months.

Diazepam can be useful for a crisis or overwhelming anxiety. When nightmares prove disturbing and anti-depressants don't help, addition of Diazepam may suppress the nightmares and restore sleep.

Carbamazepine and perhaps Lithium can be helpful where there are violent outbursts, aggression and irritability. They are particularly helpful in the condition of Malignant PTSD described earlier and where head injury is part of the post traumatic state.

The major tranquillisers, usually Haloperidol or Chlorpromazine, will be needed in cases of Brief Psychotic Reactions or where hallucinations are part of the PTSD symptomatology. These will be used only for a short duration, perhaps a few weeks at the most.

6. **Expressive Therapy:** Artistic expression of emotions and trauma can be cathartic for individuals and the community as a whole. Art, drama, story telling, writing poetry or novels (testimony), singing, dancing, clay modelling, sculpturing are valuable expressive methods in trauma therapy. The traumatised individual is able to externalise the traumatic experience through a medium and thereby handle and manipulate the working through outside without the associated internal distress. The therapist is also in a better position to understand and help the client in this process to finally establish mastery over the traumatic experience. Drama is a powerful social method to create awareness and express collective emotions.

A socio-drama on the psychological effects of war called "*Annai Ida Thee*" was produced by Kulanthai Shanmugalingam and Sithambaranathan of the Jaffna University Fine Arts Department. The roles were played by medical students, and the drama was highly effective in raising public awareness about trauma while encouraging traumatized individuals to express their emotions or seek treatment. The video of the drama enabled the process to reach a wider audience.

Rituals have a special place in third world communities. They can be a source of strength, support and meaning. Funeral ceremonies, in particular, can be powerful in supporting the grieving process and providing comfort. When they are not held according to tradition due to various reasons in a war situation this can lead to pathological grief (see Chapter 4). Thus, communities should be encouraged to go hold traditional rituals and arrangements made for this. Leisure activities such as sports, games, folk singing and dancing and religious festivals can be ways of meeting, finding support and expressing emotions.

Children in particular, who are usually unable to express their thoughts or emotions verbally, will benefit from the above mentioned expressive methods and play therapy. Structured play activity was introduced in many of the refugee camps in the North and East. They proved to be very popular with children and adults alike. The children's time could then be usefully structured and physical energy channelled in a healthy manner. More important, it helped in organising camp activity, building friendships and peer relationships and giving an opportunity for the child to bring out his or her creative impulses. One example of story telling used in Sri Lanka was the use of the *"Little Elephant"* book by Dr. Nancy Baron to build family unity and encourage positive interactions in traumatized families. Many were able to identify with the little elephant who had lost his father in the conflict.

A very innovative approach to encourage the child's imagination, creative potential and

playing impulse by linking it with the nurturing, supporting and healing power of mother earth has been started by the Canadian MacMaster University Health Reach artist, Paul Hogan, as the Butterfly Garden project in Batticaloa based on his work with the Spiral Garden project in Canada. Indrakanthi's *Sarungalei Walakulai* (Kites and Clouds) project at the Dehiwala Zoo is a similar local project in Colombo.

7. **Occupational Therapy:** Individuals can benefit from learning basic social skills and specific crafts to help them regain employment and reintegrate into society. Examples include carpentry, masonry, and gardening, as well as weaving, sewing, and cooking. In addition, occupational training, by structuring time and channelling physical activity into satisfying goals helps the individual regain his or her sense of control and mastery, his or her worthiness and usefulness and thus establish their self-respect and self-esteem. As with all activities, victims with psychological challenges need a sheltered environment where they can progress at their own pace, free from competition or pressure. In the long-term, occupational skills are empowering and produce self-sufficiency. Such training was particularly useful for poor widows whose husbands had been killed in the war. This was done with the co-operation of the Centre for Women and Development.

8. **Rehabilitation:** The rehabilitation of the individual back into his community forms an essential if not the most important part of the overall treatment. Our studies have shown that lack of financial resources, gainful employment, housing difficulties and other social problems form a major component of the individual's needs. This continuing source of problems can hamper recovery, while solving these basic needs can itself be therapeutic. Unfortunately, in the North and East such opportunities for trauma victims have been completely lacking.

In treatment centers around the world, much time and effort is devoted to meeting basic needs-such as clothing, asylum issues, and housing-as these are found to play a vital role in the individual's overall well-being and recovery. Thus, an important aspect of the treatment is to plan for the final rehabilitation of the individuals and of the family. The plan will have to be individually tailored to the needs of the individual and be therapeutic. Financial resources to help an individual re-establish themselves in society may be an essential step to regaining their self-esteem and self-respect. It may also be necessary to provide initial incentives for individuals to come forward for treatment. Many do not consider themselves as sick persons needing treatment. Others are socially withdrawn and too depressed to come for treatment. An incentive will motivate the relations or friends to bring the victim or even encourage him or her to make the effort to seek help.

A team of social workers or volunteers (as used in the Canadian centre) will be necessary

to help the client deal with various administrative problems in society, and to follow them up during the rehabilitation phase. They will have to **'befriend'** the client and form an essential part of the multi-disciplinary team dealing with the client.

Therapeutic Community - A residential centre which can integrate all the long-term therapies and provide a 'community' for the individual's recovery may be needed. A residential unit can have facilities for families to stay together so that family therapy can be carried out. Traumatized women and children could be also treated in this setting. The psychiatric care of those affected by specific disorders like Depression, Anxiety, Reactive Psychosis, PTSD and other recognised neurotic conditions could be carried out within this setting. In cases of Malignant PTSD, there would appear to be a fundamental personality change and as such a therapeutic community environment with facilities for education, vocational training, rehabilitation and leisure activities will be of benefit. During demobilization, similar programmes would have to be set up. While a centre for women affected by war and several orphanages were started, most traumatized persons are not being treated at all.

Evaluation and research will have to be an essential part of any programme. Work to establish base line statistics through population surveys using the Stress Impact Questionnaire (see Annexure 2) has been started and treatment carried out (Somasundaram & Sivayokan, 1994). Evaluation at various periods and follow-up studies will have to be undertaken.

Social rehabilitation and reconstruction of the devastated North and East of Sri Lanka is a gigantic and challenging task. In developing an overall integrated scheme for rehabilitation of the Tamil community, a systems oriented approach**,** taking into account the many interacting subsystems like the individual, family, community, cultural ethos, socio-economic conditions, ecological balance, political forces, available resources, existing

structures, and sources of help from outside would be best. What needs to be stressed here is that such a design include due consideration for the psychological processes that promote individual, family and social healing , recovery and integration. It is important that any such programme take into account the wishes of the local population concerned, that they be given an active and deciding role rather than a dependent, 'victims' role, as it promotes their overall sense of participation and thus their eventual psychological recovery. For without mental health being established first or concurrently, development and reconstruction efforts may not be of much benefit, except for the political and business interests as it will merely be for passive recipients with no motivation or interest in their own destiny.

To avoid this, emergent self-help groups and local leadership should be encouraged to resume traditional and habitual patterns of behaviour, re-establish social networks and community functioning at the grass root level (Raphael, 1986). The local skills and resources have to be tapped and utilised, if the community is to gain a sense of accomplishment and fulfilment in the reconstruction process. Provision for the non-partisan cultural working through of the shared traumatic experience in the form of periodic reminders of the loss and reiteration of its meaning, and of the heroism of those who suffered expressed in media, arts, public works, monuments, special museums & occasions of public mourning have been found to be useful in countries ravaged by civil war (Kinston & Rosser,1974). Community gatherings, meetings and religious ceremonies will allow for communal release of feeling; review and coming to terms with the **collective trauma;** socially define and interpret their experiences, as well as re-establishing social links and planning for the future.

-Pic by Dr. S. Sivathas

The dangers of 'imposing aid' from outside has been well documented (Harrel-Bond, 1988). The prospect of the complex machinery and politics of international aid agencies, UN organizations, donors, and NGOs descending on the helpless Tamil community-overwhelming and disregarding its traditional beliefs and way of life with Western notions

of "aggressive development" and "progress" seems inevitable. In the long-term this 'invasion' and imposition of 'modern' socio-economic processes may prove more deadly to the community than the war itself!

In envisioning a comprehensive and integrated approach to rehabilitation, the extremely unstable political situation on the ground, the ongoing conflict and battle for the *'hearts and minds'* of the people by the opposing forces have to be taken into account. It may therefore be better to adopt a flexible and fluid approach, and let any project or programme develop and grow with local initiative, which is sensitive and responsive to needs, demands and pressures within the community. An essential and important role can be played by outside agencies, expertise, concerned individuals, and NGO's by providing funds and resources and in encouraging and engendering such development.

But it would be wise for well meaning organizers to consider the warning issued by the powers involved that there will be no large scale rehabilitation until the political questions are settled. And psychologically, for full recovery in mental functioning, an atmosphere of peace has to be restored. Healing can take place only in a healthy post-traumatic milieu.

B. Peace

"Hatred does not cease by hatred, but only by love; this is the eternal law."
Buddha-Dhammapada (Verse 5).

The prospects for peace in Sri Lanka seem dim indeed. Violence has become so ingrained, respect for human rights and life almost nil, struggle for power so bitter and attitudes so polarised that a solution appears well nigh impossible. What started out as an ethnic conflict has escalated to produce internecine fratricide within the Tamils, a costly intervention by India, and a bloody rebellion among the Sinhalese. After all the death and carnage, the suffering and the agony, we have gone through a full circle and are back in square one, once again the Sinhalese and Tamils facing each other in a hopeless stalemate. Nobody seems the wiser, nobody, at least those in power, appear to want an amicable compromise. They talk peace but make war. Only the people are doomed to endless misery and trauma.

The society is in the grip of a spiralling vicious cycle of violence and counter-violence, terror and counter-terror. Violence breeds more violence. It brutalises the practitioner, fills the victim with a longing for vengeance, conditions the minds of growing children to think only in terms of violence and to resort to violent solutions.

Then there are the secondary effects of war-poverty, hunger, malnutrition, illness, unemployment and separation. At the same time, we have a land militarized and mobilized for war: sophisticated, powerful weapons everywhere; uniformed men with machine guns and grenades in every nook and corner; ID cards, check points, searches, security guards, metal detectors at every entrance; daily occurrences of sudden arrests, detention, disappearance, torture, deaths, bodies on the roadside; a people terrorised and cowed into passivity. The one time island paradise is turned into an inferno. We have become so habituated, so immersed in the cult of violence, that we can no longer appreciate what peace is like.

But what portends ill to the society is the habituation to violence and the malignant change in the form of violence itself (see ch.3). One may be able to justify defensive aggression against political discrimination and oppression of a peaceful minority; as a natural reaction to recurrent mob violence; as a liberation struggle to free a community denied fundamental rights. But when this aggression boomerangs inward towards the community itself, manifesting as fanatic intolerance for any differences of view, internecine fratricide, and killing of ordinary civilians, we have reached the stage of malignant transformation. What has been called **malignant aggression** by Eric Fromm (1973) is a sure sign of a spreading sickness that has to be arrested if our society is to survive.

It would seem so very simple to come to some settlement; to stop the destructive war. But then what is preventing them? Firstly, there are vested interests-economical, psychological and political, in the continuation of the war. Apart from the local national interests, various international and regional forces have also been abetting the conflict. The earlier super power rivalry, multinationals, international arms manufacturers and traders, and neo-colonial exploitation all worked to make Sri Lanka, like many unfortunate third world countries, a perpetual weeping sore in the world system. The change in the international climate with the thawing of the cold-war, increasing international co-operation and United Nations peace keeping activity, more respect for human rights and an overall a shift towards negotiation, disarmament and peaceful coexistence can be seen. Within South Asia, the geopolitical considerations of the regional super power and internal politics of the Indian subcontinent have focused on the ethnic conflict in Sri Lanka. Unfortunately for us, we have become inextricably entangled in this web of international, regional, national and local struggle for power.

As a community, the ultimate blame for creating the conditions for violence and a power vacuum inviting intervention, rests squarely on our shoulders. By our acts of commission and omission, we have given overt and covert sanction and silent encouragement to the growth of violence in our midst. Only yesterday we were content to export violence to distant areas but now it has come into our very homes, nay, driven us out of our homes.

By becoming more aware of our role in this complex problem, we may be able to act more responsibly to determine the future course of our society. For in reality, the solution to our problem is not in some other distant place, not in Colombo, Madras, New Delhi, Europe or the United Nations but right here in our own hands, in our own heart and minds. When we are ready to take responsibility and act accordingly, we cease to be passive pawns, but active creators of our future.

Ultimately war and peace are states of mind. What is within will manifest itself without. First there has to be peace within for there to be peace in the land.

Propaganda

The fundamental problem in the war in Sri Lanka is exclusive **ethnic consciousness** (see Chapter 1 & 3). To fully understand this, one has to recognise the need for **ethnic identity**.

At this point in time, it is extremely difficult, if not impossible, to transcend narrow group identities. We have been thoroughly conditioned to think, feel and behave in ethnic terms, Sinhalese or Tamil. However, if we can pause for a minute and understand how this process has been instilled and maintained, then we may well be on our way to 'liberation'.

It is important to realise that there may be several ways of demarcating group membership or ethnic identity:

1) **Language**: Tamil is spoken in South India, and in Sri Lanka by the Muslims in their homes and in the hill country.

2) **Religion**: Again Hinduism links us to India, while Buddhism to the rest of Asia and the world.

3) **Culture:** The Tamils in Sri Lanka, South India and the Sinhalese all share a similar culture vis-à-vis the rest of the world, and are essentially of the same stock (see Chapter 1)

4) **Economic**: With world market forces operating, Sri Lanka is inexorably drawn into the world economy. Locally the Tamil economy is intertwined with the South.

5) **Geography**: The island forms a natural unit with the sea as a boundary. The Indian subcontinent is also another natural whole. National boundaries some of which were drawn quite arbitrarily across maps by impatient colonial powers are only now showing their human cost.

6) **Political:** Sri Lanka and the Tamils have to recognise not only India's supremacy in the region but other super powers such the USA, Japan, etc. They are not without interest in the strategic island. Further, the dubious distinction between the internal affairs of a state where it can do as it pleases, and its foreign affairs which is open to international regulations and diplomatic pressure is another example of quite arbitrary manmade definitions which can be quite costly in terms of human life and suffering. In the present world, national boundaries are fast losing their relevance, and it may be more germane to consider remarking on the basic demarcation above(1-6) or better still, to accept the interdependence and unity of the whole world or region such as South Asia.

Children are born without any hatred for each other. In the socialisation process from infancy, they learn about themselves and their society, including group identity, its prejudices and hatreds. In this process an important part is played by the parents, relations, school, religious and other institutions. In Sri Lanka these primary socialisers have only of late started playing an important role in developing ethnic suspicions and exclusiveness and we have mainly to thank the mass media and the politicians for the construction of the present polarized reality.

From the time of Gobbles, the importance of the mass media to influence, manipulate and control the public has been known. Whenever there is a coup in the modern world, we see the new power immediately reaching for the TV and radio stations, imposing press censorship, and releasing various types of mass propaganda with misinformation and disinformation campaigns to play on the emotions, prejudices, and unfulfilled aspirations of the public.

Frustrations and discontent of the people are diverted to create a state of suspicion, hostility and fear, so that vested interests can grab, maintain, or consolidate power. This process may culminate in what has been called in lay terms as 'war psychosis'. A war situation is created where men are ready and willing to lay down their lives or kill each other, to commit murder with the sanction of society.

Here in Sri Lanka, we have seen the politicians and the media on both sides of the great divide, North and South, Sinhalese and Tamil, gradually build ethnic suspicion and hatred, kindling it into an all consuming fire, and then pouring fuel to keep it raging. Although it may be unrealistic to expect unbiased reporting, the extreme polarization and volatile material that is being routinely published speaks for the deterioration of journalistic standards.

Following the '83 riots, mass propaganda techniques reached new heights with the establishment of the state run Lankapuwath on the one hand and on the other, the Tamil information centres all over the world (the so-called Eelam lobby) and a world disinformation campaign launched for the benefit of the foreign and local forums. Sometimes the silence can be deafening, for example the Kumuthini boat massacre, where 34 passengers-men, women, and children were hacked and stabbed to death with swords and knives by the Sri Lankan Navy, found no mention in the Colombo based media, not even a passing reference. In the same way the internecine warfare or massacres of Sinhala and Muslim villagers in the East are not reported in the Tamil newspapers in the North.

Examples include the Killivedy massacre of 24 children, women and men and gang rapes

committed by the army-reported in the Colombo papers as acts carried out by the other side. Although there is frequent complaints of restriction on journalists going to Jaffna, no one bothered to visit this village in the East which was open. Similarly, the death of 120 civilians in the Navaly church precincts due to bombing by the Airforce, was hardly found newsworthy compared to the Central bank blast during the same period, which was 'splashed' all over the world.

In Jaffna, during the war, we saw the emergence of four Tamil dailies, colourful poster campaigns, local TV & radio programmes, which proceeded to put out the same inflammatory material. In totalitarian systems, continuous exposure to a single way of perceiving events, while other viewpoints are barred or unavailable, can eventually brainwash the entire community. The mere fact that it is reported in the newspaper or announced over the radio gives the material credibility and stamp of authenticity, particularly to those used to an authoritarian system. However, with time, there is evidence of a developing scepticism and discriminating judgement. As Lincoln put it "*You can fool some people all the time and all the people some of the time but you can't fool all the people all the time*".

India too joined the propaganda fray, first by giving wide publicity for the 'Tamil cause', and then doing a complete volte-face by sealing and blasting two Tamil dailies and closing down the TV station at the beginning of their intervention in October, 1987, and effectively stopped the printing of the other newspapers for over three months. Psychologically, subtle radio programmes, *'Anpu vali'* (Path of love) and *'Veti male'* (Victory necklace), ostensibly for the Indian troops, but directed at the Tamil mind, were broadcast daily by All India Radio. They effectively blanketed their military offensive of October and November, by preventing any news leaking out. The world did not know what was going on inside Jaffna, making all that happened a 'non-event' as far as the outside world was concerned. Though All India Radio and other media used to publicize events in the North and East extensively, since India had her fingers burned with the IPKF, and perhaps Rajiv's killing, news of events in the North and East are no longer reported, even though major events still make it to the international media.

The psychological use of language is another important aspect of mass propaganda. Idealistic statements are delivered on public platforms while the most gruesome and macabre activities are carried out concurrently. Sri Lankan politicians like President J.R.Jayawardene waxed eloquently on the merits of *ahimsa* while incendiary bombs were being dropped on thickly populated areas and institutionalized torture was routine in all

army camps. Some terms in practice appear to carry a different or opposite meaning, sometimes referred to as diplomatic double-talk. The so-called *'Operation Liberation'* in Vadamarachi was more an 'Operation Subjugation' than anything else. The pacifying term Indian Peace Keeping Force (IPKF) is another misnomer. Their appearance on the scene has meant anything but peace for Sri Lankans as a whole (or has meant peace of the graveyard according to the pungent editor of a popular English daily). A political analyst from Calcutta pointed out that the IPKF was sent here to keep the peace in India-a consequence of the new Indian policy of fighting her battles on foreign soil or border states, so that the security of India and her geopolitical interests are safe guarded.

It is a sobering thought that the various powers that be and vested interests still recognise the necessity to woo the public, to wage a propaganda war for the minds of the people. For ultimately, they need the public to sanction their power and need their co-operation to keep them in power, however powerless, gullible and contemptible the masses seem to them and are treated as such.

On the contrary, in a culture where the Tamil man has always prided himself in being politically aware, the need of the hour is to depoliticise and to defuse the situation. At least, from the mental health point of view, the common man needs a respite.[1] However much the politicians and the vociferous few may feel that "*all this sacrifice should not go in vain, the struggle should continue to win Eelam*". It is time to think again, to take account of the cost, to inquire what we have achieved and whether where we are heading for is the best for the Tamil people.

Too much importance has been given to politics. It has been allowed to become overwhelming and dominating in our life. The result is a society in shambles, the economy in ruin, every nook and corner of the land occupied ('saturated') by armed forces, and the ordinary man compelled to lead a life of uncertainty, tension and terror. After all, politics is only one aspect of life. Let us turn our minds to other things in our life-work, family, art, drama, music, relations, sports, ...let us lead a normal life for a change, get up in the morning with hope, grow our crops and do our daily, routine work, marry and bring up children, laugh and cry over life's small problems and go to sleep without any fear.

As a community, the lessons that can be learned from the war experience, is the need to be more discriminative and resistant to propaganda and keep politicians and politics at a healthy distance.

[1] An overwhelming ennui, a heavy inertia, a weariness of spirit, is discernible in the population as a whole and the refugees in particular, manifesting a lack of interest and volition, a lack of initiative to start anything new or to even repair the damage caused by the war, an apathetic resignation to fate to do the bare minimum, just survive and keep going. This is apart from the specific mental health disorders discussed in chapters 4,5,6 & 7.

Education

Following close on the heels of propaganda as one of the structural causes of the ethnic conflict is the educational system. Living in an area lacking natural resources & opportunities for development, education has been rightly considered an important investment for the Tamils. Education thus became a means of advancement and livelihood for many Tamils. At first a disproportionate number gained admission to higher education, particularly the professional courses in the University. It was therefore not surprising that the gradual restrictions in admission of Tamils to higher education (see Table II in chapter 1) by successive 'Sinhalized' (Nissan,1996) governments through standardisation and other systems was perceived with increasing alarm by Tamils, particularly the youth, as threatening their very livelihood. The beginnings of Tamil militancy was a reaction to this state policy in education. However, there were many inherent shortcomings in the way Tamils dealt with education that was aggravated by the State's discriminatory actions. Unfortunately, recent developments in the educational system have turned this once cherished endeavour into a big question mark as even the national examinations are no longer being held in the North regularly. The non-attendance and drop out rates have increased dramatically in the North, becoming the highest in the Island (Wickremasinghe, 1996). Ironically, what started out as a struggle for better educational opportunities has had the opposite effects.

Under the present standardised, exam oriented set up, the number of entrants to the university is fixed district wise. The keen competition between Tamil students in Jaffna, edged on by family and social pressures, pushed up the minimum marks required for admission though the total number of entrants remains fixed. This turns it into an aggressive and exhaustive attempt to get a few more marks than one's neighbour or friend at the exams, by rushing from tutory to tutory, and mugging up the notes from early morning to late at night. The real schools appear to have become a resting place between these frantic activities. Finally, after all this Herculean effort, only six percent (6000 out of 100,000) will enter the university, and out of this, only a small fraction get medicine or engineering. This inevitably means a sense of shame, guilt and frustration for a large majority of students. Some commit suicide when the results are out, others turn to alternative means of fulfilling their dream, including militancy.

Many basic criticisms of the out moded, anachronic education system has surfaced. When only such a small fraction of the students make it into the university, should not the emphasis change so that the majority will benefit. A small stream can continue to prepare for the

university. But the majority should be redirected into agriculture, fishing, technical or other occupational fields, where there is prospects for achieving employment and job satisfaction while at the same time contributing usefully to society. The recent establishment of Regional Colleges is a first step in this direction.

Education has to become broad based with choice in a variety of subjects, particularly those relevant to our situation and in keeping with the interests and nature of the child. Education as it is practised is a legacy of the colonial British system and much of the subject matter, the subjects themselves, the manner in which they are taught and then examined have all become outdated, if not quite irrelevant to our needs. A radical transformation, where the subjects and their content are of direct relevance to our situation and of use to our society is urgently needed. Basic general knowledge, creativity, experimentation and research, not exam learning, has to be encouraged and built up.

At this young impressionable age when the mind is naturally curious and creative, the body brimming with energy, the need is for development in a wide range of activities, to expand their horizons and experiences, to eventually mature into responsible adults. Apart from book knowledge, students need extracurricular activities such as music, drama, societies and clubs, sports, and outings, along with time at home for household chores and participation in family and social life.

-Saraswathy, Goddess of learning

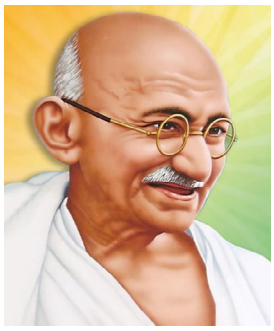
Instead of encouraging and providing the resources and opportunities for their development along their natural bend, *swabhava*, to fulfil their *swadharma* and achieve their own potential we stifle, force and mould them to our preconceived ideas and values. Students are confined to books, notes and rote learning of irrelevant material, whereas general knowledge and awareness, neglected in our educational system, is far more important. In our exam oriented educational system, libraries[2], research, general reading, creativity, laboratories are by-passed while 'the notes' become the alpha and omega of learning. It is doubtful whether an intelligent and creative mind will survive in our system. We are covertly perpetuating a constricting violence on these young minds and bodies that are straining to be free. This kind of regimentation and pressure will result in a build up of aggressive energy. Ultimately,

[2] For example, if one visits one of the libraries in our secondary schools, one will invariably find it, if one exists at all, locked up with a thick layer of dust and cobwebs due to disuse. Due to the absence of practicals in the exams, laboratories too have fallen into disuse. Sadly this has become true of the universities too. The libraries are hardly used and the lecturers rarely refer books or update their lecture notes. The universities have become glorified tutories. Research, independent thinking and discussions are not heard of.

the unrealistic values and priorities nurtured by our society engenders aggressive competition, suppression of youthful creativity and energy. This eventually leads to youth discontent, frustration, unrest and violence. Recently, before the war, Jaffna boasted a relatively high suicide (which is aggression turned inwards to the self) rate in the world, with peak incidence in youth. Sadly, this is but one of the many indicators of social pathology, reflecting the state of social ill health of our community.

If the ethnic polarisation, suspicion, enmity and conflict is to be defused, the educational system has to work to build trust, co-operation, common perceptions and goals. Unfortunately, as Reggie Siriwardena (1984) has shown (see Chapter 3), the present educational system, the text books, segregation into bilingual streams, the overt and covert lessons and attitudes taught by the teachers, have all created ethnic division, stereotypes and prejudice. The tendency to think and categorise in narrow ethnic terms have to be transcended by introducing universal issues, problems and solutions. The UNICEF programme on Education for Conflict Resolution is a valuable exercise (Wijeyasekara, 1996). A co-operative rather than a competitive spirit has to be fostered. All the ethnic groups learning together in the same classrooms, learning each other's language and culture has to be encouraged. Education has to become a means for unity and universality rather than separateness, or narrowing of consciousness.

Ahimsa



"*The moment the slave resolves that he will no longer be a slave, his fetters fall. He frees himself and shows the way to others. Freedom and slavery are mental states.*" **-Mahatma Gandhi**

This final section will attempt to address itself to the need for practical techniques to solve problems and conflict, particularly in the political arena, that will avoid the immense trauma already discussed. The Tamil community, faced with progressive discrimination and violent repression by the State, had to react either with passivity and submission or with defiance and resistance. Violent struggle would seem to be the only way against an opponent who is perceived as ruthless and cruel. It would appear to be not only more effective, but also faster and surer of its goals. But it is the intention here to show that non-violence(**n.v.**) if properly understood and practised, can be more effective, less costly and not necessarily slower, the pace set by the determination, discipline and technique of the n.v. activist and the general support from the local population.

If we examine closely the mechanism of power that permits a stare or organization to govern a particular area or people, for example the Tamils in the North, East (and Central) Sri Lanka, it soon becomes clear that it can be done only with, the conscious or unconscious, consent and co-operation of the Tamil people themselves.

"*Since all governments (whether democratic or totalitarian) are dependent on the society they rule, a regime can be weakened and shattered by the undermining and severance of its source of power. If the subjects deny the ruler's right to rule and command, they are withdrawing the general agreement, or group consent, which makes possible the existing government. This loss of authority sets in motion the disintegration of the ruler's power"* (Sharp, 1973). Central to power is the recognition and acceptance of an authority by the people and their willingness to obey. Authority and obedience can derive from legitimacy such as democratic elections, royal descent or other means consistent with the law of the land. In rare revolutionary situations, legitimacy may instead come from the "people," the "revolution," or the "struggle" against the previous authority. A ruler may capture power by illegitimate means such as by force, but later, retrospectively, attempt to establish legitimacy by such means as rewriting history, propaganda, farce elections or other claims to rule. Ultimately the source of power is the subject's mind, its acceptance of the authority's claim to rule and command. A process of shifting legitimacy was clearly visible in Tamil areas following 1983, when the Sri Lankan State, India and several militant groups lay conflicting claims to legitimate authority, sometimes at the same time.

Authority and obedience is often due to fear. Fear often stems from threat of sanctions. Sanctions may take many forms, such as social and economic pressures, but generally involve the threat of use of physical violence as punishment for disobedience. Thus, the Sri Lankan state, later India, and the Tamil militants themselves, increasingly used violence including assault, detention, torture, execution or disappearances to establish their authority. The possibility of detection of disobedience and punishment, even when small, help to strengthen and reinforce the pattern of obedience. The threat of sanction and enforcement in a minority of symbolic cases, is sufficient to obtain general obedience from the population. It is noteworthy that in Sri Lanka the local militant groups adopted repressive methods like intimidation and execution of key or symbolic members in the administrative network (e.g. Government Agents) in their attempts to disrupt this essential infrastructure of the state and thereby paralyze its function.

The citizen can be caught between the two horns of a dilemma when both parties threaten and enforce sanctions as happened in Sri Lanka before the presidential election in 1988. The JVP threatening death to those who went to work and the government threatening death to

those who didn't. The ability to impose sanctions itself derives from the obedience and co-operation of at least some subjects: "*Whether those sanctions are effective depends on the subjects' particular pattern of submission ... (Thus,), the effectiveness of even enthusiastic police and troops in carrying out their tasks is often highly influenced by the degree to which the general population gives them voluntary support (e.g. informers) or obstructs their effort. ... The compliance pattern of the subjects will largely determine the extent to which sanctions are 'required' to bolster obedience and even their relative effectiveness when used*" (Sharp,1973). But when resistance and defiance becomes strong and widespread, when large numbers are willing to suffer the consequences for disobedience, imposition of sanctions become difficult and impracticable. The effectiveness of sanctions, in the final analysis, depends on the subjects' perception of threat and fear of punishment and their willingness to stand up to violent repression.

An extreme form of fear or terror, has become a common means of vying for power in the modern world. Terror has been usually resorted to by extreme groups who find themselves in a disadvantageous position in terms of resources, personnel, compliance and support from the people in comparison to a more powerful, repressive state apparatus. Terror is then used to disrupt the smooth functioning of the regime in power and bring into question its ability to rule and administer. By creating sudden panic and terror among the people, they upset their feelings of security and complacency. Besides highlighting and publicising genuine issues that have been ignored so far by those in power, they slowly undermine the authority and obedience the rulers received from the people. Daring terrorist operations will encourage more to disobey the state and some to join the ranks of the dissidents. They are often labelled as terrorists and receive international condemnation, the world little realizes, the covert violence, the terrible repressiveness of the system the 'terrorists' are protesting against. Thus, state terrorism is the other side of the same coin and can be much more sinister in all its ramifications and generalised systemic effects, because it has the whole state apparatus and often international backing through loans or other aid. Violence is often institutionalized within the very laws -such as the PTA and Emergency Regulations in Sri Lanka (see Chapters 1 and 2)-and the entire system works to perpetuate coercive control over a subject people.

It is usually argued, and it may hold true most of the time, that the '*individual is more or less a helpless victim of vast social and political forces which impinge on him'*-even determining his beliefs, attitudes to social and political issues and consequently his obedience to the state. "*If these forces are insufficient, then there is always the repressive power of the State, which he has learned to fear*". But although obedience is influenced by powerful social forces, ultimately they have to act through the psyche of the individual. Thus, this 'consent'

may not always be automatic and "*may change in response to new events, pressures, influences, new beliefs (or new insights into old ones) and changes of perception of the established system*"(Sharp,1973). Physical compulsion affecting only the body does not always obtain obedience. For even in the case of sanction, there is a role for an act of will, for choice. For the sanction to be effective it must be feared and its consequence weighed, not always consciously, against the consequence of disobedience. Thus, one can choose to obey, thus avoiding the sanctions threatened for disobedience. Or one can choose to disobey and risk receiving the threatened sanctions. Obedience thus exists only when one has complied or submitted to the command. One may be ordered to dig a ditch and be punished for disobedience but the obedience is the result of an act of volition (the ditch can also be 'dug' in such a way that completely transforms the situation between the master and the slave, their relationship and the act of obedience). The threat of physical compulsion or sanctions produce obedience and consent only when the threat affects the subject's mind and emotions- in other words, when the subject fears the sanctions and is unwilling to suffer them. It is not the sanctions themselves which produce obedience but the fear of them. The sanctions themselves may never be applied, or may even turn out to be innocuous or imaginary. However, once there has been a major reduction of or an end to the subjects fear, and once there is willingness to suffer sanctions as the price of change, large-scale disobedience and non-cooperation becomes possible. Thus, under certain changed or revolutionary conditions, the normally pliant subjects may be willing to put up with inconveniences, suffering and disruption of their lives rather than continue to submit passively or to obey a state whose policies they can no longer tolerate. Gandhi emphasised the importance of a change of will as a prerequisite for a change in patterns of obedience and co-operation.

States and other organisations procure the obedience, co-operation and active assistance of subjects by offering incentives, such as money, security, position and prestige. People dissatisfied with the State or system may nevertheless continue not only to obey passively, but even to serve actively in what they perceive to be their own self-interest. Self-interest is most important if the ruler is to obtain the various types of assistants and helpers to run the state machinery. Once established, the ruler is able to encourage the expectation of rewards.

There can be no doubt that self-interest has played a dominant role in Tamil politics as described in Chapter 1. Favouritism, nepotism and personal interest have been key considerations in politics. The Government's oft quoted examples of token Tamils in high administrative posts (Cabinet Ministers, secretaries to the ministers, Chief Justice, IGP, A.G. etc.) in Colombo were used as convincing international propaganda to support its claim of non-discrimination. Even when certain opportunities opened up for mass non-violent

struggle, self-interest intervened. For example, the 1961 satyagraha the campaign lost its steam when the civil disobedience and obstruction began to interfere with the food rations and subsidies. Rightly or wrongly the people felt that this handout from the government was more important than the political issues involved. More recently, the Tamil parties in Colombo have co-operated with the government in power for political position, influence and survival.

It is interesting to note that in the North and East of Sri Lanka after 1983, when the State progressively lost military control over these areas, it still continued to pay the salaries, maintain a modicum of food supplies, and few other items (all with foreign aid), so that it continued to be in administrative control, at least in appearance. That the Tamil population continued to obey and play along showed the primacy of their self-interest (salaries, positions in the state, fear of sanctions etc.). That they still continue to obey (whether it is the Sri Lankan state, the Indians or the militant groups) is an indication of their lack of commitment to the so-called 'liberation struggle'. The obvious increase in the proportion of persons willing to forgo their self-interest is largely due to the success of the violent struggle in 'forcing' the state to adapt increasingly repressive & destructive methods, thereby reducing the rewards to be gained and alienating more and more of its 'once' loyal subjects.

Thus, it becomes clear that "*the most important single quality of any government, without which it would not exist, must be obedience and submission of its subjects. Obedience is at the heart of political power*" (Sharp, 1973). Obedience as has been shown is a state of mind, depending on fear of sanctions, recognition of authority, self-interest, habits and attitudes towards obedience and submission.

In Sri Lanka we have two powerful monolithic organisations facing each other with the people in-between. One is the State having legislated draconian powers to itself and institutionalized violence into a very repressive system. It has used the state apparatus and all the resources at its command to unleash organized violence against the minority Tamils (and, also, ironically against its own Sinhalese youth, the JVP). With all other means of redress apparently failing them, the Tamil youth have turned to the traditional method of combating power-counter violence which has spiralled into a civil war. In the process another monolithic organisation, the LTTE, equally repressive and totalitarian in its control, has come into being.

In these circumstances of violent repression and abuse of power by a chauvinistic state, the use of counter violence would appear justified and effective. But now, when we look back and consider the enormous cost in terms of lives, crippling injuries and psychological trauma; loss and destruction of property, possessions, institutions, employment; the plight

of refugees and homelessness, and the failure of violence to achieve any substantial result except the brutalization of a whole society, the increase of hatred, suspicion, enmity and desire for revenge, we should think again.

Non-Violence

There is no getting around the fact that non-violence (n.v.) is the only practical way of ensuing a true democratic participation by the people themselves. Thus, the n.v. struggle led by Mahatma Gandhi against British imperialism, Martin Luther King against white racism, Jeyaprakash Narayan against Indira Gandhi's excesses and Solidarity against the Polish communist regime became genuine people's movements. Non-violence is a method specially suited for women, who are socialized to non-aggressive ways of solving problems. They are thus motivated and inspired to take more active roles and participate in greater numbers as they have courageously done in many n.v. struggles around the world. Where they have participated in violent struggles, it has been subservient or rarely exceptional, never being given the leadership to direct the struggle as in the LTTE.

On the other hand, when violence is used, power invariably gets concentrated in the hands of the few, inevitably leading to repression and totalitarianism in the *'interests of the cause'* as perceived by the leader. A true mass participation in a violent struggle is not possible because of the logic of violent conflict and the nature of violence itself-issue of weapons, who is to use it, the dehumanising effect of violence, the atmosphere of mistrust and paranoia, and leadership and decisions being determined by those having the arms. '*Power flows through the barrel of the gun*' and is yielded by those holding the guns. While n.v. is best suited for a people to express their collective will, evolve a common strategy by consensus, and determine goals democratically, violence becomes a means to ambition and struggle for power where the people are simply pawns, used by the contending parties for their own purposes and predetermined goals.

There are many misconceptions about non-violence in our community and it may be worthwhile, now with the obvious cost of violence becoming apparent, to look at non-violence again but more systematically and thoroughly. Gene Sharp (1973) classifies non-violent techniques into three broad methods (**see Table 2**):

Table 1 The Methods of Non-Violent Action

(from Sharp, 1973)

1. PROTEST AND PERSUATION

A. FORMAL STATEMENTS
1. Public speeches
2. Letters of opposition or support
3. Declarations by organizations and institutions
4. Signed public statements
5. Declarations of indictment and intention
6. Group or mass petitions.

B. COMMUNICATIONS WITH A WIDER AUDIENCE
7. Slogans, caricatures and symbols
8. Banners, posters and displayed communication
9. Leaflets, pamphlets and books
10. Newspapers and journals
11. Records, radio and television
12. Sky writing and earth writing

C. GROUP REPRESENTATIONS
13. Deputation
14. Mock awards
15. Group lobbying
16. Picketing
17. Mock elections

D. SYMBOLIC PUBLIC ACTS
18. Displays of flags and symbolic colors
19. Wearing of symbols
20. Prayer and warship
21. Delivering symbolic objects.
22. Protest disrobing
23. Destruction of own property
24. Symbolic lights
25. Displays of portraits
26. Paint as protest
27. New signs and names
28. Symbolic sounds
29. Symbolic reclamations
30. Rude gestures

E. PRESSURES ON INDIVIDUALS
31. Haunting officials
32. Taunting officials
33. Fraternization
34. Vigils

F. DRAMA AND MUSIC
35. Humorous skits and pranks.
36. Performances of plays and music
37. Singing

G. PROCESSIONS
38. Marches
39. Parades
40. Religious processions
41. Pilgrimages
42. Motorcades

H. HONORING THE DEAD
43. Political mourning
44. Mock funerals
45. Demonstrative funerals
46. Homage at burial places

I. PUBLIC ASSEMBLIES
47. Assemblies of protest or support
48. Protest meetings
49. Camouflaged meetings of protest
50. Teach-ins

J. WITHDRAWAL AND RENUNCIATION
51. Walk-outs
52. Silence.
53. Renouncing honors
54. Turning one's back

2. SOCIAL NONCOOPERATION

Social boycott
Selective social boycott
Lysistratic non action
Excommunication
Interdict

B. NONCOOPERRATION WITH SOCIAL EVENTS, CUSTOMS AND INSTITUTIONS
Suspension of social and sports activities
Boycott to social affairs
Student strike
Social disobedience
Withdrawal from social institutions

C. WITHDRAWAL FROM THE SOCIAL SYSTEM
Stay-at-home
Total personal non cooperation
"Flight" of workers Sanctuary
Collective disappearance
Protest emigration (Hartal)

3. ECONOMIC NONCOOPERATION

(1) ECONOMIC BOYCOTTS

A. ACTION BY CONSUMERS
Consumers' boycott
Non consumption of boycotted goods
Policy of austerity
Rent withholding
Refusal to rent
National consumers' boycott
International consumers' boycott

B. ACTION BY WORKERS AND PRODUCERS
Workmen's boycott
Producers' boycott

C. ACTION BY MIDDLEMEN
Suppliers' and handlers' boycott

D. ACTION BY OWNERS AND MANAGEMENT
Traders' boycott
Refusal to let or sell property
Lockout
Refusal of industrial assistance
Merchants' "general strike"

E. ACTION BY HOLDERS OF NANCIAL RESOURCES
Withdrawal of bank deposits
Refusal to pay fees, dues, and assessments
Refusal to pay debts or interest
Severance of funds and credit
Revenue refusal
Refusal of a government's money

F. ACTION BY GOVERNMENTS
Domestic embargo
Blacklisting of traders
International sellers' embargo
International buyers' embargo
International trade embargo

(2) THE STRIKE

A. SYMBOLIC STRIKES
Protest strike
Quickie walkout (lightning strike)

B. ACRICULTURAL STRIKES
Peasant strike
Farm workers' strike

C. STRIKES BY SPECIAL GROUPS
Refusal of impressed labor
Prisoners' strike
Craft strike
Professional strike

D. ORDINARY INDUSTRIAL STRIKES
Establishment strike
Industry strike
Sympathetic strike

E. RESTRICTED STRIKES
Detailed strike
Bumper strike
Slowdown strike
Working-to-rule strike
Reporting "sick" (sick-in)
Strike by resignation
Limited strike
Selective strike

F. MULTI-INDUSTRY STRIKES
Generalized strike
General strike

G. COMBINATION OF STRIKES AND ECONOMIC CLOSURES
Hartal
Economic shutdown

4. POLITICAL NONCOOPERATION

A. REJECTION OF AUTHORITY
Withholding or withdrawal of allegiance
Refusal of public support
Literature and speeches advocating resistance

B. CITIZENS NONCOOPERATION WITH GOVERNMENT
Boycott of legislative bodies
Boycott of elections
Boycott of government employment and positions
Boycott of government departments, agencies and other bodies
Withdrawal from government educational institutions
Boycott of government supported organizations
Refusal of assistance to enforcement agents
Removal of own signs and place marks
Refusal to accept appointed officials
Refusal to dissolve existing institutions

C. CITIZENS'ALTERNATIVES TO OBEDIENCE
Reluctant and slow compliance
Non obedience in absence of direct supervision
Popular non obedience
Disguised disobedience
Refusal of an assemblage or meeting to disperse
Sit down
Noncooperation with conscription and deportation
Hiding, escape and false identities
Civil disobedience of "illegitimate" laws

D. ACTION BY GOVERNMENT PERSONNEL
Selective refusal of assistance by government aides
Blocking of lines of command and information.
Stalling and obstruction
General administrative non cooperation
Judicial noncooperation
Deliberated inefficiency and selective non cooperation by enforcement agents
Mutiny

E. DOMESTIC GOVERNMENTAL ACTION
Quasi-legal evasions and delays
Noncooperation by constituent governmental units

F. INTERNATIONAL GOVERNMENTAL ACTION
Changes in diplomatic and other representation
Delay and cancellation of diplomatic events with holking of diplomatic recognition
Severance of diplomatic relations
Withdrawal from international organizations
Refusal of membership in international bodies
Expulsion from international organizations

5. NONVIOLENT INTERVENTION

A. PSYCHOLOGICAL
Self-exposure to the elements
The fast
(a) Fast of moral pressure
(b) Hunger strike
(c) Satyagraha fast
Reverse trial
Nonviolent harassment

B. PHYSICAL INTERVENTION
Sit-in
Stand-in
Ride-in
Wade-in
Mill-in
Pray-in
Nonviolent raids
Nonviolent air raids
Nonviolent invasion
Nonviolent obstruction
Nonviolent occupation

C. SOCIAL INTER VENTION
Establishing new social patterns
Overloading of facilities
Stall-in
Speak-in
Guerrilla theater
Alternative social institution
Alternative communication system

D. ECONOMIC INTERVENTION
Reverse strike
Stay-in strike
Nonviolent land seizure
Dance of blockades
Politically motivated counterfeiting
Preclusive purchasing
Seizure of assets
Dumping
Selective patronage
Alternative markets
Alternative transportation systems
Alternative economic institutions

E. POLITICAL INTERVENTION
Overloading of administration systems
Disclosing identities of see agents
Civil disobedience of "neutral" laws
Work-on without collaboration
Dual sovereignty and parallel government

1. **Protest and persuasion:** Involves symbolic actions such as marches, meetings, petitions, vigils, and other demonstrations intended to persuade opponents or express a group's disapproval and dissent.
2. **Non-cooperation:** Social, economic and political non-cooperation such as economic boycotts and strikes.
3. **Intervention:** Where the non-violent group takes the initiative by such means as satyagraha, sit-ins, non-violent obstruction, non-violent invasion and parallel government.

Same methods may be used for different purposes. For example, fasts and hartals could be symbolic acts to show protests, means of non-cooperation or powerful means of psychological influence. As can be seen from **Table 2**, there are numerous techniques and their application requires skill, determination and knowledge. It was with the insight of a political genius that Gandhi decided on the highly successful 'salt march' in 1930. It takes considerable experience and knowledge to pick the place, time and technique.

A golden opportunity presented itself to the Tamils after the 1983 racial riots when the State demanded all officials to sign an oath of allegiance under the 6th Amendment. After thrashing and sending the Tamils running to their homes, the imposition of the requirement at this point of time was designed as an act of humiliation, as the amendment had no intrinsic urgency or aim except '*appeasing enraged Sinhalese sentiments*' as President Jayawardene put it. That the Tamils signed, except for a very few exceptions (one ended up committing suicide due to social pressures, the Tamil MP's exiled themselves and the others eventually capitulated), rationalizing it as a mere formality, showed the primacy of self-interests over self-respect. Again, the imposition of ID cards, clearly an affront to the identity and right of a community to live freely in its own land, was not resisted as Gandhi did in South Africa. The ID card was soon to become more important than life itself, symbolizing the whole repressive system. Non-violence is not an all or none method and its effects, not limited by single failures, can be cumulative and build up a momentum of its own, both in the spirit of the practitioners and in the reaction of its opponents.

Non-violence has a long history and has been surprisingly successful under very adverse circumstances. Among others, the examples of the resistance of Roman plebeians, the defiance of American colonists (notably the refusal to pay taxes), the boycotting by Irish peasants, the strikes by St. Petersburg, German non-cooperation against the Karp Putsch, the fasts of Algerian nationalists, Maoris in New Zealand, the civil disobedience by

Gandhians, the refusal of African Americans to ride buses in the US; closer to home we had the peaceful protests led by Chelvanyagam in 1956, the satyagraha and disobedience campaign of 1961; and more recently, Prabhakaran's and Theleepan's fasts against the Indians and the Pasayoor and Vigitharan protests against the LTTE can be mentioned.

It is often argued by Tamils that non-violence could never have worked against the ruthless Sinhalese State. They further argue that non-violence may have worked in India because the British were a moral, decent and ethical people who would respond sympathetically to the non-violent principles. But England's final capitulation had nothing to do with moral principles but was based on cold calculation of self-interest, its recognition of the enormous cost of repression, the lack of profits and its inability to rule in the face of determined non-cooperation.

The military strategist Liddel Hart concluded that Hitler's Generals found non-violence in Norway, Denmark and Holland far more baffling than the violent resistance in other occupied countries (Sharp, 1973). In the same way, successive Sinhalese State leaders by their acts of omission and commission, have gradually created the situation for the emergence and growth of the reactive militant violence and its assumption of foremost place among the Tamils by side-lining, ignoring and even ridiculing the more moderate elements. It was as if they, perhaps unconsciously, understood and were more comfortable with violence, even respecting it more.

Violence

The persistent exposure of human right violations and abuse of power by the Sri Lankan State had led to international condemnation and increasing pressure from donor countries. The pre-conditions with regard to the human rights record for loans and aid has forced the Sri Lankan State to take steps to remedy the situation. On the other hand, by waging a violent struggle, particularly when it spread to involve massacres of Sinhalese civilians, terrorist attacks which killed non-involved civilians and foreigners, internecine killings and execution of internationally respected Tamil civilians like Kandasamy, the Tamils lost considerable support, both from among Sinhalese and internationally, that had risen spontaneously after the 1983 riots. Although many Tamils have argued that this sympathy has not achieved much, it is easy to underestimate the effectiveness of the pressure and control these external bodies can exert. Obviously, it is largely subtle and invisible, acting over long periods and working through multiple channels. Perhaps the most important group of all is the Sinhalese people themselves who are the ultimate source of the State's power. To be able to carry on as it did, the State had to wage a

sophisticated propaganda campaign of disinformation and misinformation, to hide the true nature of the conflict from the Sinhalese people. Instead of confronting this and chipping away at this source of power, violence confirms the State's propaganda, polarizes attitudes and hardens hostility and hatred. The greatest blow to the 'Tamil cause' was loss of sympathy and support from neighbouring South India which had all along extended a helping hand and received thousands of refugees with compassionate friendliness. Even during the period India was fighting a war in the North and East of Sri Lanka, support and assistance to those effected was unstintingly given. But when violence spread into South India, particularly with the killing of Rajiv Gandhi, there was radical change in their attitudes and emotions. Sri Lankan Tamils were viewed with alarm and plainly rejected as disseminating a 'gun culture'. For violence was never a part of the Tamil culture and has been abhorred in its spiritual literature. Even internationally, perhaps partly due to the loss of support from India, the Tamils of Sri Lanka have become an ostracized community with stringent and special regulations regarding visas, entry or stay in countries, detention in special camps, forced repatriation and the like. We have become veritable outcasts on the international scene. The LTTE has consistently exploited any space, any opening given to the Tamils anywhere for their own ends, thereby eventually closing that space and causing severe resentment against the Tamils as a whole.

The problem with violence is that its inherent nature is such that it inevitably grows to a more malignant form (Fromm, 1975). Violence dehumanises and brutalizes the user (see case histories in ch.5). With the first act of killing, once the hands are soiled with blood as it were, the usual inhibitions and taboos that operate internally are broken. With this lack of restraint and loss of conscience comes a feeling of power, absolute power. A marked intolerance for difference of opinion, a fanatic faith in ones own view or a blind obedience to leadership, a conviction of infallibility, a callous indifference to pain, suffering and life of others manifests itself. Further, violence and the shedding of blood creates an atmosphere of raised emotions, hostility, hatred, fear, suspicion and paranoia that makes clear thinking impossible. The act of injury or killing creates a whole host of enemies (the brothers, kin, comrades of the deceased) seeking revenge. Thus, the violent become enmeshed in a world of fear and paranoia. They are unable to trust anyone and are always on the alert and vigilant for possible and imagined attacks. The life of Prabhakaran in his bunker is a good example of such a life condemned to eternal vigilance. Study of war veterans who have committed atrocities show an increase of stress symptoms such as startle reactions, terrifying dreams, distrust, behavioural problems and drug abuse (Yager, Laufer & Callops, 1984). Moreover, there is a danger

of getting addicted to the thrill and excitement of violence described by Rosenbeck (1985) as Malignant PTSD. They develop a severe self-loathing and self-hatred, sometimes "*a manifested and boastful and exhibitionistic pride in being loathsome*" perpetuating spirals of violence and counter-violence. In children, their personality development can become permanently distorted and deformed due to their experience of violence.

In contrast non-violence has a more wholesome effect on its practitioner, strengthening him spiritually and developing in him what Gandhi called '*soul force*'. Mahatma Gandhi's prescription for non-violent struggle basically constituted a strict discipline and gradual spiritual development, a *sadhana* if you will, to evolve a *satvic* state of mind and soul that radiates *Sathya* and *ahimsa* where no harm, physical, verbal or mental, is intended or practised towards anyone including the adversary or 'enemy'. The 'soul force' or love towards the opponent has the power to transform him in ways that defy rational explanation. This was what Martin Luther King was talking about when he said, "*We should love our enemies because love is the only force capable of transforming an enemy into a friend*". It is quite evident that amidst our violent pursuits we have wandered far from the way of love extolled by the Tamil sages like Thirumoolar. The means are as important as the ends, for the methods used transform the user and the final end in the process. Thus, while non-violence practised at a political or practical level is effective as Gene Sharp (1973) has shown, Gandhi's technique goes a step higher, into the spiritual realm and thus should have the additional attraction to us, who claim to be steeped in a culture that gives pride of place to spiritual development.

-Pic by Dr. S. Sivathas

On a social level, when non-violence is properly practised with the participation of the general population, it binds and unites the people, the young and the old, the men and the women, giving them a sense of purpose and pride in their action. Further, it brings the

sympathy of other groups and builds inter-group relationships. Instead, we chose to follow the path of violence in the so-called 'liberation struggle for just rights of the Tamil people'. In the beginning there was much altruism and enthusiasm as many Tamil youth dedicated themselves to the cause. But what started out as defensive aggression has undergone a malignant transformation in the heat of the struggle for power and had turned self-destructive. Tamils killed Tamils. Those who dared to question, to speak out against the increasing repression were eliminated or forced to flee. Slowly the community lost all its most able and gifted leaders, intellects, professionals and workers. A submissive obedient society was moulded by intimidation, terror and elimination. Instead of a gradual increase in social consciousness that one would expect after a decade of liberation struggle, there was increasing constriction and narrowness. A more ominous manifestation of the constricting consciousness was the narrow nationalism shown by the massacre of Tamil Muslims in the East and their expulsion from the North.

The political and social control became total. The Tamils soon lost under their own rulers even the restricted basic rights they had once enjoyed under their 'oppressors'. By July 1990, the life and property of all Tamils was taken over by decree. There was no question of self-determination. Everything was pre-determined, they had to just fall in line. Such basic freedoms of speech, assembly, travel, the press, and freedom from displacement, arbitrary arrest, detention, torture, death have been lost. Even at a tender age children are being increasingly recruited, indoctrinated and trained into efficient militant machines. Although late by a few years, George Orwell's "*Nineteen Eighty Four*" became a reality in Jaffna. 'Big Brother' (Anna) looking over the shoulder, movement songs and propaganda over loud speakers and the radio and the media, a community completely brainwashed, has all come to pass.

Thus, the consequence of a decade of violent struggle is a society bound and shackled, moulded to think along narrow nationalistic lines. Tragically, all this was done with the best of intentions, in an effort to 'liberate' Tamil society. One can argue whether such fascist and totalitarian developments are an inevitable result of violent struggle.

The Tamil Mind

Thus, the Tamil mind is today faced with two types of terror-one external and the other internal. The external terror is quite obvious and its reality has been accepted internationally, particularly since the 1983 ethnic riots and more recently even by discerning Sinhalese in the South. The increasingly discriminatory policy (in education, land, employment) and repressive measures of the Sinhalese State and periodic mob violence up to 1983 against the Tamils is well documented. This book is replete with examples and consequences of

this terror campaign. The same terror also characterised the brief Indian administration of the North and East. The only lesson from all these attempts at violent suppression of protestation deriving from the unsolved grievances of a minority is that it does not work. What results is an intractable mess.

The second from of terror is from within. The tight control exerted by the LTTE over the Tamils and the overwhelming tendency for Tamils to be silent or avoid criticising the LTTE in any genuine way has led to the completely totalitarian regime we have. Some may say that this is out of fear and this is true to a great extent. The LTTE has consistently destroyed any criticism and weeded out all opposition to its rule, its network reaching internationally. But it is also due to gut emotions of support for Tamil nationalism and the perception that LTTE represents that. But is that really true? Didn't the LTTE policy lead to destruction and, as an unplanned result, a cultural genocide as described below rather than growth and development? Can't we at least open a little space, some room to air other views, a chance to make LTTE responsive to the needs of the Tamil people it claims to represent? Can't it be made to listen to the voice of the people? The overwhelming cry is of war weariness. Many Tamils particularly expatriates and those living outside the war zones, would hesitate: Now they say is not the time to be self-critical and wash our dirty linen in public, the Tamil cause is at a critical juncture, we have to present a united front not weaken ourselves by differences of opinion. But can't we have some say in the direction the struggle is to take, where we are going? Is it that the LTTE (which in reality means the special tendencies epitomised by Velupillai Prabhakaran) only knows best? Are we willing to take responsibility for the other negative aspects of LTTE rule which we choose to deny, ignore or claim ignorance of? Just as the Sinhalese State has militarized its side, the LTTE too has built up a world-wide totalitarian structure.

Consider the fate of women and children caught in this trap in the North and East. Young men are no longer joining the militants in the desired numbers due to disillusionment with the whole system. They have developed the insight and realization that those not directly affected sadly lack. Most of them want desperately to get out. So, it has become necessary to recruit children and women in their place. Though there is no overt compulsion, the whole system covertly works towards this end. From full scale indoctrination at schools and through the mass media, to the strict restrictions on outward travel of those in recruitable age through a pass system (and of course, the atrocities of the Sri Lanka forces), impel the children and women from deprived sections of society to become the cannon fodder for the terrible war. Is this what is being advocated from the safety of Western countries where children of those vocally supporting the LTTE are happily attending school?

Unfortunately for the Tamils, the LTTE which claims to be their sole representative and obviously won some legitimacy in their eyes, has repeatedly spurred diplomatic means to exploit political opportunities to the advantage of the Tamils. They have been a fierce guerrilla force of international repute and renown but have tended to always think in military terms. Thus, the Tamil civilian population have been pulled through several, "unnecessary" wars and suffer all the consequences (as outlined in this book) because of this military and paranoid mindset. Had these situations been diplomatically exploited with adroit skill, the result may have been an advantageous position for the Tamils and an avoidance of a prolonged war. For example, the Indian Peace Accord of 1987 was actually a golden opportunity for the Tamils. Perhaps we will never again get the terms offered in the accord and that with India as a guarantor. It was a gross and costly mistake for the LTTE and by extension for the Tamils to become the ones to oppose it and bring on the wrath of India on ourselves when they had actually come with arguably good intentions towards the Tamils. This is not to excuse the role of India with all its resources. Which if anything has to bear the moral blame, particularly for the consequences of the war that ensued with the breakdown of the Accord in October, 1987. For India approached the problem in a superficial way with no understanding of the intricacies of the problem. The whole operation was conducted from a North-Indian Perspective.

Similarly, the so-called Eelam war II in May 1990 and Eelam war III of April 1995 could have been avoided or at least not precipitated by "our side". it is noteworthy the LTTE fraternized with all these forces or "enemies" at one time or another and later branded others as "traitors" for doing the same at other times. A problem with the LTTE in particular, and the Tamil mind in general, has been the fanatical intolerance, paranoia towards other interest groups or points of view. In fact, a careful analysis of the aforementioned situations leading to war will show that it was this deep paranoia of other Tamil militant groups that led the LTTE to opt for war, without in the least considering the consequences for the civilian population. The consequences of the 1995 exodus from the Jaffna Peninsula for the estimated 500,000 people in terms of death, disease, thirst, hunger, hardship and suffering are indescribable. But more when a people are uprooted from their natural habitat to which they have strong ties, a slow psychological and cultural death takes place. When we think of the cultural institutions including libraries that have been left behind and deterioration in social norms and practices that are going to result (as happened to other refugee population), it represents a kind of cultural genocide in the offing. Many self-acclaimed Tamil organizations commonly charge the government of genocide, but what are we doing to ourselves if not self-destruction. There has been no gain to the Tamil people or even to the LTTE-politically or militarily by these costly exercises. We are back to square one after

all the death and destruction. The recent reply by some Jaffna University academics to the UTHR publication of the Exodus admitted what was stark reality to the 500,000 displaced that the LTTE was compelled to order the exodus but then gave various justifications or rationalizations. This is a good sign. At least some space for dissent is being created even at this late stage.

Helmut Thielicke (1967) clearly describes how the totalitarian Nazi regime came to be established on the Germans. He explains how the dreadful truth (of the internal terror and the nature of the regime) was repressed from consciousness. He clearly warns us "*Take care lest you end up in exactly the same place where we are today*". It is important to realize that much of this self-imposed repression, censorship and standard rhetoric that is spewed out is unconscious. An internal censor will control what is said or even thought. External control becomes unnecessary. Commenting on the surprising lack of external control (check points, guards, searches, public signs of arms etc.) in Tiger controlled Jaffna, an ICRC representative said after much careful observation of Tamil society towards the end of his period, "the barbed wires are inside the brain". Thus, it became doubly difficult and painful to became aware of what is really going on.

We have to realize that in a way we are all responsible, keeping silent and passive as violence spread among us. So much so that, today, we are hardly conscious, almost blind to the nature of what is going on around us. If the Tamil community is to break out of its tragic plight, it can be only through a genuine liberating effort where they become aware that they are the ultimate source of power and thereby exercise their inalienable right to determine their future. As long as we continue to cling to our slavish mentality, we continue to need an authority to rule us. To be free, we have to be able to think and act on the basis of freedom, on the fundamental realization that we hold the reins of power. Nothing is more suited for achieving this collective realization than a nonviolent struggle that effectively involves all in a participatory process. However much we may now be caught up in the logic and vicious cycle of violence, in the end (perhaps only after the hatred, conflict and aggression has run its course) a lasting and peaceful solution among civilized people can only be non-violent.

The Sinhalese

Going back to the more obvious first form of external terror, in the prevailing climate of polarized ethnic hatred and prejudice, the Tamils stereotype the Sinhalese as brutal, violent and without a moral conscience. The Sinhalese chauvinists, they maintain, will only understand the language of violence, nonviolence will not evoke a chord of sympathy and is bound to fail against such violent repression. Even if we accept for the moment this

extreme image of the Sinhalese, it has already been pointed out that nonviolent strategy expects violent suppression from its opponent. It works simply by refusing to obey. But it is a fatal mistake not to differentiate the State from the Sinhalese people. The Sinhalese people themselves are, as a whole, compassionate with a firm belief in the Buddhist principles of *Meththa, Maditha and Karuna.*

There can be no excuse for all the atrocities committed against the Tamils. Much of what has happened has been the work of unscrupulous manipulation by politicians and misinformation about each other. It is the State itself and chauvinistic fringe that has waged a relentless violent campaign against the Tamils. A telling rationalization for the violent Tamil reaction has been the signs of genocide by the State. Whole villages or youths between specific ages have been cold bloodedly massacred. The systematic extermination of Tamil villagers in strategic areas such Manal Aru, Gal Oya, and Madura Oya in the North and East to make way for Sinhalese colonists are further evidence of deliberate nefarious policy. The indiscriminate bombing and use of napalm-like incendiary material ranks with the worst war crimes.

It is this basic fear of the malevolent intent of the Sinhalese that is the driving force for the Tamil cause, its call for separation and liberation struggle-not Tamil nationalism. And it is this underlying fear that the Sinhalese people will have to reassure the Tamils about if there is to be any meaningful reconciliation. As the majority community with all the resources at its command, the onus is with Sinhalese people to recognize in a genuine way the suffering the Tamils have been through and make amends. A negotiated political settlement or paper guarantees of devolution will not substitute for genuine reconciliation from the heart, difficult as it may be in the present climate of ethnic hatred and hostility. The Sinhalese and the Tamils themselves have gone through violent inner convulsions that at times make the ethnic divisions pale into insignificance. Some believe it is the inevitable Karmic reaction to the violence that had been unleashed, being the playing out of mental propensities (*vasanas, samskara)* from perpetuating violence on others. We have to break this spiralling cycle of violence and counter-violence, violence breeding more violence, the Karmic Wheel of action and reaction, if we are to find peace or Nirvana. But it is difficult to see how violence can be given up, now that the wheel has been set in motion; it has become so ingrained into our psyche, especially in the children who are now growing up in this milieu created by us.

Conclusion

Obviously, it is in the best interests of the people of this island to stop this costly and pointless war. It is time to '*turn back the tide of madness and cruelty, and restore, create, build sanity, love and peace*'. But why are we unable to do it? It is the subtle but complex psychological processes we have been discussing about, that is intervening between war and peace. Peace can be brought about only by becoming painfully aware of these deep unconscious psychic forces within us and by an act of will to change the direction of their action. Only this can be the basis of freedom and reconciliation.

REFERENCES

1. Caplan, G. (1961). An approach to Community Mental Health. G Grune & Stratson, New York.
2. Damain, Fr., S. (1994). *Ula Vallathrurai* (Counselling in Tamil). Author, Jaffna
3. Frankl, V.E. (1959). *Man's search for meaning: An introduction to logotherapy.* Boston: Beacon Press.
4. Fromm, E. (1973). The Anatomy of Human Destructiveness, Penguin Books, Middlesex, England
5. Horowitz, M.J. (1986). Stress Response syndromes, Jason Aronson, USA.
6. Kinston, W. & Rosser, R. (1974) Disaster: Effects on Mental and physical state, Journal of Psychosomatic Research, 18:437-456.
7. Harrel-Bond, B. (1988). Imposing Aid, Oxford University Press, UK.
8. Natchinarkinian, C.S. (1994). Current Pattern of health Care and Resource Allocation. In Victims of War in Sri Lanka-A Quest for Health Consensus. eds. Arulanantham, K., Rathneswaren, S. & Sreeharan, N. Medical Institute of Tamils, London
9. Nikapota, A. & Samarisinghe, D. (1995). *Training Manual for Helping Children in Situation of Armed Conflict.* UNICEF, Colombo.
10. Nissan, E. (1996). *Sri Lanka*: *A Bitter Harvest.* Minority Rights Group, London.
11. Raphael, B. (1986). When Disaster Strikes, Hutchinson, Australia.

12. RED BARNA 'Bitter Waters'-The Effects on Children of the Stress of Unrest. source: RED BARNA, Oslo.

13. Rosenbeck, R. (1985) The Malignant Post-Vietnam Stress Syndrome, American Journal of Orthopsychiatry, 55:2, 319-32.

14. Sharp, G. (1973). The Politics of Non-violent Action, Extending Horizon Books, USA.

15. Siriwardene, R. (1984). National Identity in Sri Lanka: Problems in Communication and Education in Sri Lanka: The Ethnic Conflict, Committee for Rational Development, Navrang, New Delhi.

16. Somasundaram, D.J. (1993). *Mana Vadu (*Psychological Trauma in Tamil). University of Jaffna, Jaffna.

17. Somasundaram, D.J. & Sivayokan, S. (1994). War Trauma in a Civilian Population, British Journal of Psychiatry, 165, 524-527.

18. Sivarajah, N. (1993). Nutritional Status of the Children in Jaffna. Dept. of Community Medicine, University of Jaffna.

19. Thielicke, H. (1967). Between Heaven and Earth. James Clarke & Co, London.

20. Veer, G. van der (1993). *Psychotherapy with refugees.* Amsterdam:SCS.

21. Wickremasinghe, K.I. (1996). *Education in Sri Lanka.* Paper presented at the Review Workshop on Children's Rights and Development, Ministry of Health, Colombo.

22. Wijeyeyasekera, A. (1996). *Education for Conflict Resolution*. Presentation at the Asia-Pacific Expert Group Consultation on the UN Study on the Impact of Armed Conflict on Children, Manila.

23. Yager, T., Laufer, R. & Callops, M. (1984). Some Problems Associated with War Experience in Men of the Vietnam Generation. Archives of General Psychiatry, 41:321-33.

Appendix I
Relaxation Techniques

When we face difficulties and stress in our life, changes take place in our body and mind. For example, when we experience sad or frightening events many of us are unable to sleep or eat properly. Often, we experience a sense of foreboding and tension or rapid beating of our hearts. These physical and psychological changes help us to function well in emergencies. As such, these changes (fear, tension, being keyed up) help us.

However, if these changes are severe or continue even long after stressful events, then they become harmful. When these changes exceed a certain limit, they begin to interfere with our ability to function adequately. For example, our inability to move or speak properly in a sudden stress is due to these changes going over the limit. Therefore, these changes become harmful and adversely affect our coping capacity.

In the same way, if these changes continue long after the stressful events, they will affect our daily life and ability to maintain an equilibrium when faced with problems. Sometimes it can lead to psychosomatic diseases.

We will consider relaxation techniques here. There are four methods that have been shown by scientific research to produce relaxation and help in certain psychological conditions like anxiety and psychosomatic diseases.

1. Breathing exercises
2. Progressive Muscular Relaxation
3. Regular Repetition of Words
4. Meditation

When following these methods, it is helpful to observe a few preliminary conditions:

a. Place-a quiet, well ventilated place, free of disturbances.
b. Time-morning and evening, twice a day for ten minutes before taking meals.
c. Clothing-loose, cotton clothes are best.

It is important to do each exercise in a peaceful, relaxed state. A feeling of urgency to do something difficult or attempt to try and finish it quickly, like running a race, should be avoided at all cost. Once one has become familiar with the method, it can be done in other places and times when the need arises. For example, when faced with a stressful situation or in a frightening environment, or even during a leisure period, one can do the breathing exercises and/or the repetition of words and gain mental tranquillity. By regular practice it is possible to create a healthy, peaceful life.

1. Breathing Exercises *(Pranayama, Ana pana Sati or Mindful Breathing)*

When we are disturbed mentally, our breathing becomes shallow and irregular. This in turn will cause changes in our physical body and mental state. By learning to make our breathing deep and regular, we can oppose the above physical and psychological changes and thereby produce a state of mental and bodily peace.

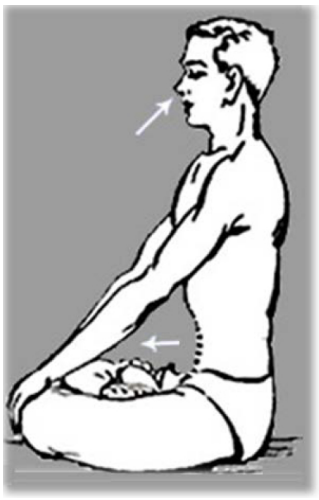
For this exercise, it is necessary to choose a posture that is not too rigid. Assume any posture that is comfortable (e.g. sitting in a chair or ground, lying on a bed; or assume the lotus or siddhasanam) and in a relaxed, tranquil state observe yourself breathing in and breathing out for a few minutes.

Often, we will notice that predominantly our chest is being used for breathing. But for this exercise we have to learn to mainly use our abdomen for breathing. We can observe that the breath goes in when our chest and abdomen expand. We should now learn to breath slowly, continuously and deeply. We can do this easily if we concentrate on our abdomen slowly expanding (one can place the palm of one's hand on abdomen for this) while we draw in our breath deeply. Then, by allowing our chest and abdomen to relax the breath will go out automatically. Try to do this slowly and continuously. There should be no noise while breathing. In this way, observe the breath going in and out several times. Slowly and gradually learn to shift your breathing to the abdomen so that most of the breathing is done by the movement of the abdomen muscles.

After this, slowly count up to three in your mind while breathing in, and again count up to three while breathing out. Over several weeks, slowly increase the count depending on your capacity. Alternatively, you can say a meaningful word or mantra such as "OM" to yourself. "Ooo" as you breath in and "Mmm" as you breath out. Slowly increase the time taken to say O and M. Breathing, should never be difficult or labored, but it must always be done in a comfortable way.

In the Pranayama method, breath in for a fixed count, then hold your breath for a fixed count, and then let your breath out for a fixed count (ratio 1:4:2 respectively or its multiples). In Anapana Sati, observe the respiration as the breath flows in and flows out, feel the air touch the nose and upper lip or the abdomen moving up and down. One should try to concentrate his mind well on the breathing alone.

Breath in → Breath out



Breath in slowly by expanding your chest and abdomen muscles

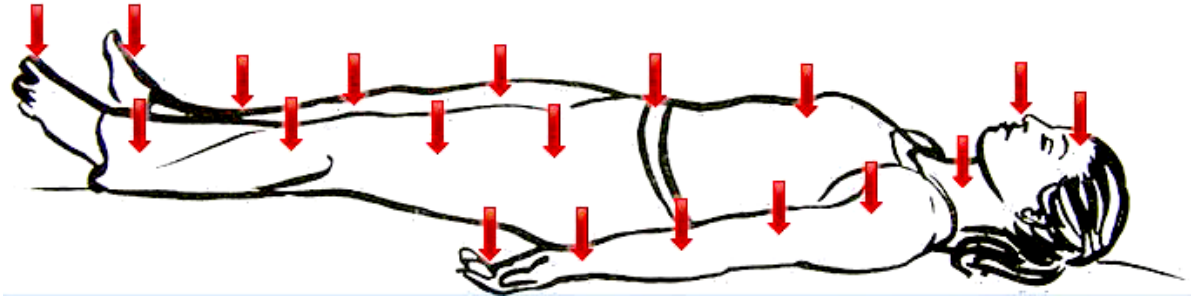
Let your breath out naturally by relaxing your chest and abdomen muscles

2. Progressive Muscular Relaxation (Shanthi or Sava Asanam, *Mindful Body Awareness*)

When the muscles remain in a state of continuous contraction due to stress, both physical and psychological symptoms can manifest, including tension headaches, backache, neck pain, joint pain, weakness, and fatigue. Further, there may occur psychological fear, tension, tightness, being easily startled, overreactivity and irritability. Conversely, these mental states can produce chronic contraction or tension of muscles leading to the above physical symptoms. By practicing the following exercise, you can obtain release from these painful physical and psychological complaints by creating a state of relaxation, calmness and peace.

Lie down flat, facing up, on a mat or bed. Spread out your legs, and let your hands lie by your side. Close

your eyes and observe your breathing in and out slowly, without hurry, and deeply as described above. You should relax your body and lie like a " Lifeless Corpse"



Slowly relax each part of your body and muscles while saying "**shanthi, shanthi, shanthi**"

Beginning from your toes, slowly relax each part of your body. First concentrate your mind on your toes and while relaxing (loosening or letting go) say to yourself "My toes are relaxed, "***shanthi, shanthi, shanthi***". In this way, move up your body-toes, soles, ankle, calf, knee, thigh, anus, abdomen, back, chest, fingers, hands, elbow, arms, shoulders, neck, face and finally head. As you relax each part, say to yourself "My..... is relaxed, "***shanthi, shanthi, shanhti***". A deep sense of tranquillity, calm and peace should be felt in that part. As you move up, the part already relaxed should not again become tense, but remain relaxed. At the end, the whole body should be deeply relaxed . If someone should lift your limb and let it fall, it should fall like a lifeless log. Experience this peace for a few moments. Do not get up suddenly, but slowly move your body a little and become aware of the body before getting up.

In the Western scientific method called Jacobson's progressive muscular relaxation each group of muscles are strongly contracted before relaxing, so that you can appreciate the difference between the tensed and relaxed state.

Progressive muscular relaxation is a good way of falling asleep. For those with sleeping difficulties just do this exercise after lying down to sleep.

3. **Repetition of Words** (Mantra, Jappa, Prayer Beads, Rosaries, Dzhikr, T.M.)

In this method, repetition of a word or phrase will create a state of mental peace. The mantra that has been taught to you by your Guru using Rosaries or the Jesus prayer (*Jesus Christ have mercy on me*) , a holy verse, Buddhist (*Buddhang Saranang Gachchami*), Islamic Dzikir, Takbir, using Tasbih (*Subhanallah or Allah-Hu*), God's name, meaningful word or saying, or simply, the basic Pranava mantra "*OM*" can be used. First, repeat your chosen word to yourself again and again (as many times as you can e.g. 100 times or traditionally, 108 or its multiples) twice a day. After some time, this repetition will come easily, sometimes happening without effort or your awareness. Next, after a month of above practice, repeat your chosen word without making a sound, moving only your tongue and muscles of speech. Do this for a few months. Then, repeat your chosen word without moving any of your muscles. After doing this for few months, just think of your word in your mind.

4. Meditation (Contemplation, *Vipassana*)

For meditation you can sit in a posture that is comfortable to you or assume Padmasanam or Sidhasanam. It is important to keep your back straight. It is helpful to meditate daily at the same time and place that is quiet and without disturbance. You will need to choose an object for meditation. Your deity, God, respected saint or elder, a beautiful natural scene or flame can be chosen as the subject of meditation. Alternatively, the above mentioned word or phrase can be used. Very simply, you can mindfully observe your breath (for example, the in flow and out flow of breathing at the tip of your nose or the rising or falling of the abdomen).

First assume the posture comfortable to you (where you can sit for a long period without feeling pain), then do the breathing exercise, relaxation and repetition of word as described above. To meditate, you will have to concentrate your mind and keep it continuously on the object chosen by you. If the mind becomes distracted or goes off onto another subject, slowly become aware of it and gradually, without force, bring it back to the object you have chosen. Very softly, without too much force or effort, you must learn to keep your mind on your chosen object. Slowly practice this for a few minutes, increasing the time as you go along. In time you will be able to meditate on an object for a continuous period.

Concentrate your mind & keep it on a fixed object.

Note: As the above exercises are similar to Yoga, Buddhist, Christian or Islamic practices, it is best to learn these methods from an experienced teacher like your Guru, monk, priest, Ven. Bhiku, Rev. Father, Sister or Uman.

Appendix II
Stress Impact Questionnaire (SIQ)

No. :..... Date :.....

The following questions will help to detect your physical and psychological disabilities after stress and if necessary, provide treatment. Your written answers and replies during the interview will be kept confidential. If you wish, you need not give your name or full address. Please ask if you cannot understand any questions. If you wish to provide any more information, please use the space at the end of the section titled 'Other' after noting the number of the question. Further, the details are given overleaf for questions marked with an asterisk(*).

Section I

1.01 Full Name :.....

1.02 Age :..... 1.03 Sex :.....

1.04 a) Address before stress :.....

.....

b) AGA Division :.....

c) District :.....

1.05 a) Current Address :.....

.....

b) AGA Division :.....

c) District :.....

1.06 Ethnic Group :..... 1.07 Religion :.....

1.08* Marital Status :.....

1.09* Number of living children :..... 1.10 Number of dependants :.....

1.11* Educational status :.....

1.12 Occupation :.....

Details :.....

1.13 Your family income per month :.....

1.14 Do you receive help through food stamps or janasakthi :.....

1.15 Have you suffered from an any important disease :.....

If yes give details :.....

1.16 Have you suffered from mental illness :.....

If yes give details :.....

1.17 Has any of your blood relations suffered from mental illness :.....

If yes, give relationship :.....

1.18 Other :.....

Explanatory Notes

1.08	Marital Status	:	Single/Married/Widowed/Divorced/Separated
1.11	Educational Status	:	i.e. 5th std/'O'level/'A' level/graduate
1.12	Occupation Details	:	Self-employed/Daily wage-earner/small or big business/Farmer/ Fisherman/Private enterprise/Government worker

Section II

If you or your relations or friends have experienced stress (problems, suffering, ill-effects) due to the recent disturbances, please fill in the following questionnaire. It is important first to answer Yes or No by placing a tick (✓) in the appropriate column. If you answer Yes please indicate severity as mild (small, little, less) moderate (average, somewhat) or severe (increased, more, lot, heavy). When recording the time, please indicate the date of onset, and duration. If you cannot remember the exact date of onset, give an approximate date or the month.

	No	Yes	Mild	Moderate	Severe	Date of onset	Duration	Details
2.1 a. Did you suffer any injuries?								
b. Was there any danger or threat to your life?								
2.2 a. Did your relations/friends suffer any injuries?								
b. Did your relations/friends sufer death								
c. Did your relations/friends face any danger or threat to their lives?								
2.3 a. Was there any ' threat' to your property?								
b. Was there any damage to your property?								
2.4 Did you experience any of the following : a. Detention								
b. Assault								
c. Bombing, Shelling, Shooting								
d. Torture								
e. Sexual Aggression								
2.5 Did you suffer any of the following due to the disturbances: a. Unemployment								
b. Financial Problems								
c. Lack of Food								
d. Illness								

2.6 Did your relations/friends experience any of the following :
Detention, assault, sexual aggression, torture, disappearance.
If yes, details :.....

2.7 Did you witness any of the following :
Death, detention, assault, sexual aggression, torture, injuries.
If yes, details :.....

2.8 Were you displaced due to the disturbances?
(i.e. new place, distance, cause, difficulties in travel)
If yes, details :.....

2.9 Did you experience any other stressful or shocking event
(i.e. unnatural death of loved one, marital discord, unemployment)
If yes, details :.....

2.10 Did you experience any similar stress before.
If yes, details :.....

2.11 Others :

Official Use

Objective

Stress

Subjective

Section III

If you have developed any physical complains (symptoms) following the stress mentioned in Section II, please fill in the following questionnaire. As in Section II please answer by placing a tick (✓) in the appropriate column, first whether present as Yes or No, and then the severity as mind, moderate or severe. The time should be recorded as the approximate date (or month) of onset, duration (in weeks or month) and frequency as how many time in a day or week it occurred. If the complaint or symptom clearly developed after the stress mentioned in section II please mention that in the onset column (e.g. two weeks after 2.4A).

	No	Yes	Mild	Moderate	Severe	Onset	Duration	Frequency
3.1.1 Weakness								
3.1.2 Body pain								
3.1.3 Joint pain								
3.1.4 Backache								
3.1.5 Paraesthesias								
3.1.6 Numbness								
3.1.7 Coldness of hand and feet								
3.1.8 Headache								
3.1.9 Tremor								
3.1.10 Giddiness								
3.1.11 Hearing problems								
3.1.12 Visual difficulties								
3.1.13 Oral ulcers								
3.1.14 Dryness of the mouth								
3.1.15 Feeling of obstruction in the throat								
3.1.16 Dyspnoea or wheezing								
3.1.17 Cough								
3.1.18 Chest pain								
3.1.19 Palpitations								
3.1.20 Breathing difficulties								
3.1.21 Burning sensation in the stomach								
3.1.22 Abdominal pain								
3.1.23 Loss of appetite								
3.1.24 Loss of weight								
3.1.25 Nausea / Vomiting								
3.1.26 Constipation								
3.1.27 Loose motions/ diarrhoea								
3.1.28 Increased frequency of urination								

	No	Yes	Mild	Moderate	Severe	Onset	Duration	Frequency
3.2.1 Itching								
3.2.2 Loss of hair								
3.2.3 Excessive skin condition details								
3.3 Sexual Problems (only tick those that apply)				No	Yes	Onset	Duration	Frequency
3.3.1 Increased sexual feelings								
3.3.2 Decreased sexual feelings								
3.3.3 Loss of interest/ pleasure in sex								
3.3.4 Menstrual abnormalities								
3.3.5 Abortion								
3.3.6 Premature delivery								

3.4 Did you receive any treatment for the above mentioned?
If yes give details :.....

3.5 Other complaints : (e.g. fever)

PHYSICAL EXAMINATION

General Condition :..... Nutrition :.....

Deficiency :..... Skin :.....

C.V.S R.S G.I.S G.H.S Musculo-skeletal

Pulse BP Resp.Rate Epigastric Tenderness

Muscle Tenderness

Diagnosis :..... Treatment :.....

Section IV

If you have developed any of the following psychological complaints (symptoms) after the stress/es described in section II, please answer yes and no, give the severity and onset, duration and frequency as before as in section III. If any of the symptoms clearly occurred after the stress noted in section II please note under onset mentioning the specific stress (e.g. 1 month after 2.1.1).

4.1 Immediate and transient (hours at most), symptoms (reactions), following severe (shocking stress)	No	Yes	Mild	Moderate	Severe	Onset	Duration	Frequency
4.1.1 Shock/Dazed/Stunned								
4.1.2 Depressed								
4.1.3 Anxiety/Fear								
4.1.4 Anger								
4.1.5 Disoriented/Aimless behaviour								
4.1.6 Overactivity								
4.1.7 Withdrawal								
4.1.8 Confused behaviour								
4.1.9 Loss of memory for event			Partial		Complete		Onset	Duration
4.2 Persistent longer lasting symptoms following different stresses	No	Yes	Mild	Moderate	Severe	Onset	Duration	Frequency
4.2.1 Repeated thoughts of the event								
4.2.2 Repeated dreams of the event								
4.2.3 Situations/events/stimuli resembling or evoking memories of the stress event cause/ trigger the old emotional reaction								
4.2.4 Loss of interest/involvement								
4.2.5 Detachment								
4.2.6 Loss of emotional feelings								
4.2.7 Hyperalert/easily startled								
4.2.8 Disturbed sleep/unable to fall asleep								
4.2.9 Feelings of guilt describe								
4.2.10 Loss of memory								
4.2.11 Difficulty in concentrating								
4.2.12 Avoiding situations reminding/ resembling traumatic event								
4.3 Fear/Anxiety								
4.3.1 a) Fear of specific situations/objects								
b) Extreme panic lasting for few minutes								
c) Long lasting, general fear of anxiety								

4.3.2 Tensed up/unable to relax								
4.3.3 Feeling calm/peaceful								
4.3.4 Excessive thoughts/worries								
4.3.5 Restless, disturbed feelings								
4.4 Fearful dreams/nightmares								
4.4.1 Sadness/disgust								
4.4.2 Crying easily/fearfulness								
4.4.3 Slowing of thoughts and activities								
4.4.4 Happiness in daily events								
4.4.5 Feelings of worthlessness								
4.4.6 Feelings of hopelessness								
4.4.7 Feelings of heiplessness								
4.4.8 Thoughts of death								
4.4.9 Feeling of having reached life's end								
4.4.10 Pessimistic about the future								
4.4.11 Elation/enthusiasm								
4.4.12 Suicidal thoughts								
4.4.13 Suicidal attempt If yes, give details								
4.5.1 Feeling easily annoyed or irritated								
4.5.2 Temper outbursts								
4.5.3 Frequent arguments								
4.5.4 Having urges to break or smash things								
4.5.5 Having urges to harm someone								
4.6.1 a) Tendency/desire to withdraw from society or be alone								
b) Tendency/desire to leave or move away to another place								

4.6.2 Have there been any changes in your relationship with others after the stress, if yes give details

(With whom? e.g. wife, children, relations, friends. Mention whether relationships have improved or deteriorated).

4.7 Are you in the habit of using any of the following substances? Has there been any change in the patten of use or have you developed any new habits after the stress?

	Before Stress		After Stress	
	Quantity	Frequency	Quantity	Frequency
4.7.1 Smoking 1.				
2.				
4.7.2 Alcohol 1.				

2.				
4.7.3 Hard (addictive) drugs				
4.7.4 Medicine 1.				
2.				
3.				

4.8

Grief following the death of a loved one due to the disturbances: details (why, who, how)	No	Yes	Mild	Mod.	Sev.	Ons.	Dur.	Fre.

4.9.1 Abnormal or strange belief.
If yes, describe :.....

4.9.2 Hearing or seeing things that are not there.
If yes, describe :.....

4.9.3 Behaving in abnormal ways,
If yes, describe :.....

4.10 Changes in your beliefs after stress.
4.10.1 Religious beliefs.
If yes, describe :.....

4.10.2 Philosophy (Social, political).
If yes, describe :.....

4.11 Functional disability
(e.g. in carrying out self-care, daily activities, work).

Other:

For Office Use

Mental State Examination

Appearance and Behavior :.....

Mood :.....

Other :.....

Diagnosis :.....

Cause :.....

Treatment :.....

.....

General

1) How administered (Self(s) / Interview (I))

Section I) II) III) IV)

2) Date: Place:

Time taken:

3) Assessment of subject's

(a) Understanding

(b) Concentration and Attention

(c) Motivation

(d) Reliability

4) Interviewee's name:

Position:

About the Authors[1]

"*The pen is mightier than the sword*" - Edward Bulwer - Lytton, 1839

"…writing down the experience of war itself, is the testimony of the author, and may be personally cathartic by releasing the bitterness, frustration, the anguish and the tragedy of it all. It is in the final analysis, a testimony to a people and land ravaged by war." *-page 266*

Foreword:

Veena Das, is Professor Emerita in the Department of Anthropology at the Johns Hopkins University. Her areas of theoretical specialisation include the anthropology of violence, social suffering, and the state. Das has received multiple international awards including the Ander Retzius Gold Medal, delivered the prestigious Lewis Henry Morgan Lecture. She was named a foreign honorary member of the American Academy of Arts and Sciences and is a corresponding Fellow of the British Academy. She has received honorary doctorates from several Universities in the USA, UK, and Switzerland . She has been awarded the Guggenheim Fellowship and has also received prizes from the University of Geneva and Calcutta University. She taught at the University of Delhi from 1967 to 2000. She completed her PhD in 1970 under the supervision of M. N. Srinivas from the Delhi School of Economics. She was professor of anthropology at the New School for Social Research from 1997 to 2000, before moving to Johns Hopkins University, where she served as chair of the Department of Anthropology between 2001 and 2008, and was the Krieger Eisenhower Professor of Anthropology.

History:

Rajan Hoole, born in 1948, graduated in Electrical Engineering from the University of Ceylon in 1971, followed by a BSc in Mathematics from the University of London and a DPhil in Mathematical Logic from Oxford in 1982. He worked as an electrical engineer for the Public Utilities Board, Singapore, from 1973 to 1980, and three years as lecturer in Mathematics at the National University of Singapore from 1982. From 1985 until retirement in 2015, he worked as Lecturer in Mathematics at the University of Jaffna with a break of 20 years after the murder of Dr. Rajani Thiranagama in 1989, who with him, Dr. K. Sritharan and Daya Somasundaram wrote the book, The Broken Palmyra, dealing with violence and struggle. Hoole and Sritharan continued to publish reports of the University Teachers for Human Rights (Jaffna) posted on uthr.org until the war ended and Hoole returned to the University. During this period he published three books, Arrogance of Power in 2001, Palmyra Fallen in 2015 and Sri Lanka's Easter Tragedy in 2019.

[1]Currently

The Psychological Aftereffects of Torture:

Dr Anna Zeffertt, (Anna Doney) - Consultant Clinical Psychologist. BSc University of Reading, Psychology & Zoology (1981), DPhil University of York, Experimental Psychology (1986), MPhil University of Edinburgh, Clinical Psychology (1993). Anna worked in the National Health Service UK from 1991 to 2015 as a Clinical Psychologist specialising in Child and Adolescent Clinical Psychology, Paediatrics and therapy for Trauma conditions. Her career took her to Edinburgh, London and Cambridge. She has worked in private practice since 2015 as Director of a UK organization, providing a broad range of clinical psychology therapy to children, teenagers and adults in Cambridge.

In 1988 to '89 Anna worked for Quaker Peace and Service, (head office London). During this time she was based as a Peace and Reconciliation aid worker in Sri Lanka, working in Colombo, Jaffna and northern areas. She set up the Association for Health and Counselling, known as Shanthiham, in Jaffna (1988-89) and The Family Rehabilitation Centre, in Colombo (1990-91). For this latter project she worked as project researcher and coordinator for The International Centre for Ethnic Studies. As a Founder Member of both Counselling organisations Anna was involved in training volunteers in Counselling skills, research in assessing the trauma needs of populations in the war zones, staffing both centres, setting up supporting Board Membership structures and gaining start-up funding through bodies such as Sri Lanka Canada Development Fund, Rehabilitation Centre for Victims of Torture (Denmark) and NORAD. Anna had two extended visits to The Medical Foundation for Care of Victims of Torture in London to study models of working with ex-detainees and to learn specific therapies for Post Traumatic Stress Disorder to deliver in training to staff and volunteers in Sri Lanka and to implement in the field. Over the past three decades Anna has regularly returned to Sri Lanka for visits to AHC-Shanthiham in Jaffna and to FRC in Colombo, and to the field offices of both organisations. She has provided some training and staff support and has followed with great interest the development of both organisations as they diversified into psychosocial work across Sri Lanka island into rural areas.

Scarred Minds:

Daya Somasundaram, is emeritus professor at the University of Jaffna, and a consultant psychiatrist working in Northern Sri Lanka for over three decades. He has worked as a consultant psychiatrist at Glenside Hospital; with indigenous mental health services; supporting those coming as refugees and asylum seekers in Australia at Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS), and is a clinical associate professor at the University of Adelaide. He retired as a consultant from the Wide Bay Mental Health Services, Hervey Bay, Queensland, Australia. He has also worked in Cambodia for two years in a community mental health programme with the Transcultural Psychosocial Organisation. He has functioned as co-chair of the subcommittee on PTSD formed under the WHO working group on stress-related disorders during the ICD-11 revision process. Apart from teaching and training a variety of health staff and community-level workers, his research and publications have mainly concentrated on the psychological effects of disasters, both man-made wars and natural tsunami, and the treatment of such effects. He has co-authored ***The Broken Palmyra: The Tamil Crisis in Sri Lanka: An Inside Account.*** His book ***Scarred Minds: The Psychological Impact of War on Sri Lankan Tamils*** describes the psychological effects of war on individuals, while ***Scarred Communities,*** describes psychosocial consequences of disasters at the community level. He also functioned in two national bodies, as the co-chair of the Task Force on Psycho-social Support, Office for National Unity and Reconciliation (ONUR), and on the UN mandated Consultation Task Force on Reconciliation Mechanisms, Sri Lanka. In retirement, he is involved in studying the health impact and creating awareness of transborder hazardous air pollution during the NE monsoonal blowing from northern India and Bangladesh. In addition, he is trying to establish an ecofriendly wellbeing yoga and meditation centre at Thapovanam in Allaipiddy and Mullaithivu.

தபோவனம்
ECO WELL-BEING VENTURE

Thapovanam

Center Road, Ward 2, Allaipiddy, Velanai,
Jaffna District, Northern Province 40048, Sri Lanka.
Tel. No.: +94 71 234 5673
e-mail: thapovanamjaffna@gmail.com

Thapovanam: **Embracing Serenity, Nurturing Wellbeing**

A nature based recreational yoga and meditation centre located in Allaipiddy island, Jaffna, Sri Lanka.

Introduction: Thapovanam stands as an oasis of tranquillity on the enchanting Allaipiddy island. Rooted amidst lush greenery, echoing birdsong, and the gentle whispers of the seaside, Thapovanam is a recreational yoga relaxation and meditation centre devoted to fostering holistic well-being.

Location: Nestled on Allaipiddy island situated 7 km distance from the heart of Jaffna, Northern Province, Sri Lanka. Thapovanam is strategically positioned to provide an immersive experience in nature. The natural plants, their calming shadows, and the rhythmic sounds of the waves create an idyllic environment conducive to self-discovery and rejuvenation.

Vision: We aspire to provide a haven where individuals, families and authentic groups find balance, tranquillity, and a deeper connection with themselves, dedicated to nurturing holistic well-being and a place for Tapas.

Vision Statement for Thapovanam:

At Thapovanam, we envision a haven of serenity amidst the enchanting allure of Allaipiddy island, cradled off Jaffna, Northern Province, Sri Lanka. Our vision is rooted in the belief that amidst lush greenery, harmonious birdsong, and the soothing whispers of the seaside-an ecofriendly environment, practices can be undertaken to produce physical, mental, and spiritual wellbeing.

We aspire to create an immersive sanctuary where individuals, families and authentic groups can escape the chaos of the external world and embark on a transformative journey toward self-discovery, mindfulness, and rejuvenation. Thapovanam seeks to be more than a destination; it is a profound experience that fosters tapas, a deep connection with nature, oneself, and the spiritual dimensions of well-being.

Our vision is to cultivate an environment that encourages the exploration of yoga, meditation, and spiritual practices, providing a refuge for individuals, families and groups seeking balance and tranquillity. We aim to be a haven where the mind, body, and soul find harmony, and where the natural beauty of our surroundings becomes a catalyst for personal growth and inner peace.

Thapovanam's vision extends beyond being a mere peaceful retreat-it is a commitment to creating an oasis where the rhythm of nature intertwines with the pursuit of holistic wellness and tapas. We strive to be a destination that not only embraces the present moment but also inspires a lasting sense of well-being for all who seek refuge within our tranquil haven.

In essence, Thapovanam envisions itself as a timeless sanctuary, offering a respite from the demands of modern life, and inviting individuals, families, and genuine groups to embark on a journey of self-development, and harmony among the natural splendour of Allaipiddy island.

Mission: Our mission at Thapovanam is to extend a heartfelt invitation to both local residents and global travellers, urging them to escape the incessant, stressful demands of the outside world. Our retreat accommodation is designed as a sanctuary, free from the distractions of the modern era, including the consumption of alcoholic beverages, drugs, or smoking. Thapovanam encourages individuals, families, and authentic groups to take time out to immerse themselves in the practices of healthy living, nurturing food, tapas, yoga, meditation, and spiritual growth.

Unique Offerings:

1. **Organic Living:** Thapovanam takes pride in its commitment to organic and eco based living. Guests are welcome to prepare their own meals or have it prepared using fresh vegetables harvested from our organic gardens, promoting a nourishing and sustainable lifestyle.
2. **Yoga and Meditation:** : Our centre offers dedicated spaces for tapas, yoga, and meditation without specific affiliations compatible with all religions, offering guidance and courses from experienced instructors. Thapovanam caters to individuals, families, and authentic groups of all levels, providing a platform for both beginners and seasoned practitioners to deepen their practice.
3. **Holistic Activities:** Thapovanam is a hub for holistic activities aimed at nourishing the mind, body, and soul. From invigorating swims and tranquil boat rides viewing and visiting offshore corals to refreshing cycling, jogging, walking, and contemplative moments of sitting, feeling the famed white sands of the seacoast under your bare feet, and the wind, sun, shade on your body; experience the profound silence, stillness deep within and Shanthi-a peace that passeth all understanding; there is an activity for every inclination.
4. **Eco friendly culture:** Thapovanam is committed to practices, lifestyle, beliefs, and values that promote sound ecological principles, conservation, non-exploitation, stimulate growth and development with respect for nature and long-term sustainability. Promoting greenery in the form of diverse, native grasses, plants, herbs, and trees; restoring Allaipiddy's coastal pristine environment of sand dunes, palmyra forests and ground freshwater that have through recent destruction of palmyra trees and sand mining resulting in sea erosion and salt water intrusion into groundwater through analog reforestation and Miyawaki forests; refilling of soil and sand; protecting and nurturing animal and bird life; using organic fertilizers, avoiding synthetic pesticides and chemicals would form part of the culture. Waste management, with minimum use, maximize reuse, recycling of plastics, composting of organic waste, and periodic removal of abundant plastic debris and pollution washing ashore. Ecological control of pests and vectors, mosquitoes
5. **Community Education for wellbeing:** Regular education programs on health, social and spiritual topics; herbal and plants identification for school students; training for community level workers, discussion groups, seminars, lectures, publications of free e-books. Provide facilities for outings, retreats and camping for community groups and schools like medical students, the Nuffield school for deaf and blind, scouts, elderly, widows, and children.
6. **Ashram:** Genuine seekers can find refuge to practice Tapas, an ashram with board but be expected to do some service depending on capacities and stage of development.
7. **Self-sustaining, non-profit ventures to meet running and maintinance costs:** Donations from e-books and publications. Renting basic accommodations, cottages with food; nurturing and cultivating palmyra, coconuts, vegetables, herbs, and sea products; to sell produce, run local hand and small industries with local women, disadvantaged and disabled as non-exploitative, self-managed cooperatives; siddha Ayurveda herbal massage and herbal bath; counselling & support for individual stress and minor mental health issues, family problems.

Guidelines for Well-being: To maintain the sanctity of the Thapovanam experience, guests are kindly requested to refrain from the consumption of alcoholic beverages, drugs, or smoking within the premises. These guidelines contribute to creating a pure and undisturbed atmosphere, fostering an environment conducive to spiritual practices and personal growth.

Community and Learning: Thapovanam is not just a destination; it is a community that welcomes families to join and partake in shared activities. The centre serves as a place for learning, where individuals, families and authentic groups alike can discover the art of yoga, the joys of organic living, and the ineffable spiritual benefits of connecting with oneself.

⚠ *Severe transboundary air pollution during NE monsoonal blowing period that affects South Asia region. Mosquito problem during rainy season but all eco-sound methods of mosquito control will be used at Thapovanam*

In conclusion, Thapovanam is not merely a destination; it's a transformative journey. A journey into the heart of nature, yoga, and self-discovery. We invite you and your family to embrace this unique experience, leaving behind the clamour of the outside world to find tranquility, and true well-being at Thapovanam.

Retreat. Rejuvenate. Rediscover

OM Shanti Shanti Shanti

Donations for the maintenance, running costs and pro-social programmes at **THAPOVANAM** are welcome.

Kindly deposit your donations to our account below:
THAPOVANAM YOGA AND MEDITATION CENTRE
Current account No.: 1000769751
Commercial Bank, Velanai, Sri Lanka.
Swift Code: CCEYLKLX

Acknowledgment and Receipt will be issued.

Boundless Benevolence

Mother, most gracious fountain of endless energy
You're Nature, renewing itself in the form of Fire, Water, Wind, Earth and Ether
Mother, most gracious I salute you!

You, the full moon drawing patterns on our compound
The gentle rain and the surging sea are my parents
You my mother, I your child
This life's your boon, my sole force
My mind is drenched with thy love

Thoughts of you sway my dreams

The morning sky your eyes compassionate
The hot sun and the cold windy rain
Are but manifestations of thy infinite care for us
Your radiant glance and your loving closeness
Your days and your nights the nourishing sap coursing through the roots

Thoughts of you sway my dreams

The days change like the ceaseless surge of waves
The spark lights the wick' the lamp sheds light

Thoughts of you sway my dreams

-Tamil original: N. Sivasithamparam (2005)

-Translated by: S. Pathmanathan

Set to music for the post-tsunami healing work[1]

Recorded music available

[1] In the immediate aftermath of the tsunami, many were focused on the destructive side of mother nature. Fisherman were afraid to return to sea. As part of the post-tsunami recovery work, this song was composed and recorded to see things in a balanced way and move forward. The song was conceptualised by Kuzhanthai Shanmugalingam (with team inputs), penned by Mr. N. Sivasithamparam, and its melody was composed by Thavanathan Robert. It was recorded at Sapthami Kalaiyagam, and the music was arranged, recorded, and balanced by Mr. G. Murali. Robert et al. sang the song.

Sea Mother - கடல் மாதா (Kadal Matha), கடல் அன்னை - (Kadal Annai)

There is an urgent need for individuals affected by the war, their families and their communities, to heal from the scars of war, both in the short and long term. Future generations will have to be saved from the transmission of the trauma and its repercussions. While the past has to be remembered, acknowledged and put to rest; the present and future have to be rebuilt with mended relationships, reconciliation, psychosocial and economic rehabilitation, meaningful values, true justice, and forgiveness; thus, restoring genuine peace, culture, and hope.

தபோவனம்
ECO WELL-BEING VENTURE
ISBN: 978-624-98963-6-9
9 786249 896369
800.00